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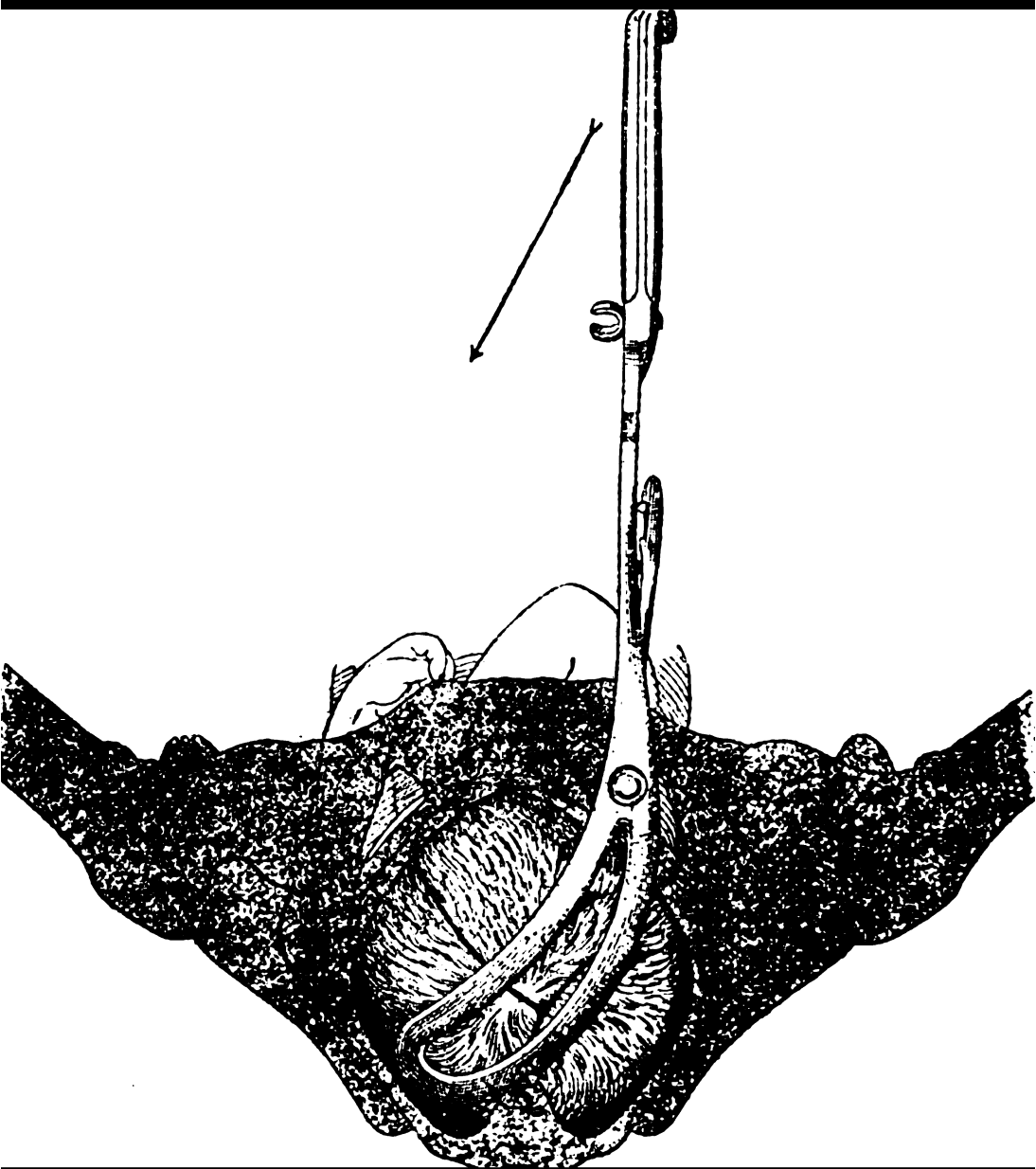
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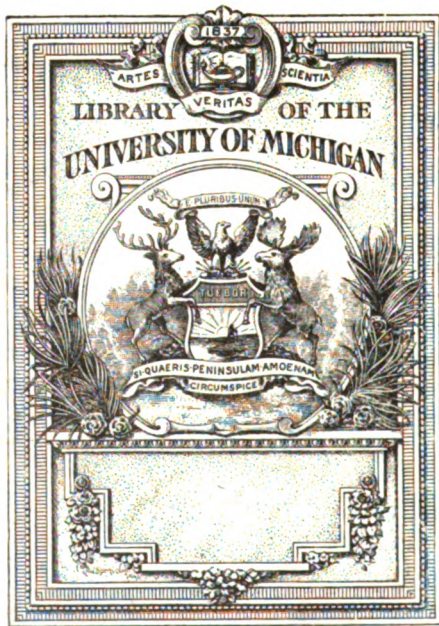
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EDITOR, B. F. UNDERWOOD, M. D.,  
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## INCOMPLETE ABORTION.

BY SHELDON LEAVITT, M. D.,

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College and Hospital, Chicago.*

**P**ARTURITION at full term is a physiological process; but a premature expulsion of the product of conception may be regarded as pathological. An outcry is sometimes raised against interference with a physiological action; but that argument does not apply with the same degree of force to abortion. In a large percentage of cases, abortion remains incomplete until completed by artificial means. It is quite true that many of the cases that are thus artificially concluded, if left to the action of natural forces would ultimately end in a complete clearance; but it is a part of the office of medicine and surgery to rescue humanity from inconvenience and suffering, as well as death. By resorting to artificial means, in a careful and cleanly manner, the patient is at once rescued from menacing environment, and is hastened on her way to recovery.

After an obstetrical experience of considerable proportions, extending over a period of nineteen years, I am fully

convinced that the average case of abortion remains incomplete for a period considerably outlasting that with which it is charged. The clinical history is briefly one of slow uterine dilatation, accompanied by pain and blood loss, followed by expulsion of the embryo, or fetus, and succeeded at last by what appears to be the complete mass of secundines. When the events follow one another in such an order, the practitioner is usually contented, and leaves the case with considerable assurance that all is well. Another very common course is expulsion of the embryo, followed by a period of brief repose, and then by pains or hemorrhage. The examining finger finds a mass of secundines protruding from the os uteri, and removes it with comparative ease. This is again taken to be a completion of the act, and the patient receives corresponding assurance. Now, how often does it happen, after the occurrence of such phenomena, that we learn, by subsequent events, that, after all, we have been too hasty in our conclusions? Here is a snare which the most wary feet do not always escape. Indeed, I have become convinced that, in the larger percentage of miscarriages, sufficient detritus is left behind to compromise the health, and even the life, of the patient, by affording peculiarly favorable conditions for the multiplication of diseased germs, which, in moderate numbers, are often found even in women who escape serious manifestations of their effects.

In view of all this, we are led to believe that the time is not far distant when the obstetric surgeon will be looked upon as a great conservator of the woman's interest in nearly all cases of abortion, and will be confidently summoned to use his curette upon the endometrium, always under the most rigid antiseptic precautions, with most gratifying prophylactic effects. I took this position four years ago at the meeting of the American Institute of Homeopathy, and my convictions with regard to the wisdom of it have since but deepened.

I have never seen harmful results from a post-abortion

curettage; and, with the exercise of wise precaution, under the hand of a skillful obstetric surgeon, it should never be a harmful procedure. At the same time, no one has the temerity to deny that it is an operation which ought not to be undertaken by a physician who questions the superlative importance of surgical cleanliness.

I venture to make these matters of precaution emphatic, because I have seen so marked disregard of them in the practice of many physicians; but it is unnecessary to enter upon details here.

The physician is not unfrequently called to women who have received no medical attention during, or immediately succeeding, the abortive act; and to others who have been seen by a physician only after the extruded matter has been destroyed. In the first instance it was presumed by the patient and her friends that the total product of conception had been expelled, and the physician was called at last because of hemorrhage or signs of septic infection. In the second instance, the medical attendant who was called, not having the extruded substances for examination, and finding no clear evidence of incomplete abortion, probably assumed that the uterus was empty. In such instance the time ultimately arrived when evidence of partial retention became conclusive, and made clear the demand for some form of intervention looking to uterine clearance.

In such a case there can be no controversy over the nature of the procedure which ought to be undertaken, as it is clearly curettage. Due preparations having been made, the woman is anæsthetized and put in the lithotomy position at the edge of the bed. The only instruments required are retractor, two or three bullet forceps, uterine dilators, a sound, and a curette. It is not often necessary to use the uterine dilators, as in such cases the cervical canal is usually patulous enough to receive the curette. The douche bag should be at hand, and the bed arranged with reference to drainage into a suitable vessel placed at its side. The perineum is retracted, the cervix seized with



bullet forceps and drawn within easy reach, and the curette introduced.

In using the last named instrument one should keep in mind the necessity of going over every part of the uterine cavity in a careful, but thorough, manner. Those surfaces that appear to yield the most decidual tissue should receive most attention ; but the possibility of uterine perforation is not to be forgotten, and undue force scrupulously avoided.

In doing this operation the curette need not be removed at the end of each stroke, but the loosened tissue should be encouraged to accumulate posteriorly, from which location it may readily be removed.

After curettage, the uterus ought to be douched, and then wiped out with dry cotton or gauze. In some instances it is well to pack. When this is done, the primary packing may be allowed to remain for twenty-four or forty-eight hours, provided pain or elevated temperature does not demand its earlier removal.

There should be but a slight bloody discharge after the uterus has been thus thoroughly emptied, and recurrence of a free flow is *prima facie* evidence that the work has not been thoroughly done.

If the temperature has been high before the operation, it is usually at once lowered ; and, unless sepsis has been profound, further progress of the case is most satisfactory.

Curettage of the uterus, when done without an anæsthetic, and in disregard of the precautions mentioned, is, in general, unsatisfactory and dangerous.

There are remedies which contribute a certain amount of aid in these cases of incomplete abortion, and among them stands pre-eminently sabina. China has been spoken of in high terms by some observers. It is peculiarly suitable to cases which have been attended by much blood loss. Pulsatilla has also often rendered good service. While these remedies may fail to expel the placenta, and thereby relieve the woman of the efficient cause of her disturbance, they are capable of rendering valuable aid to extractive measures by encouraging uterine action, and of contributing to a gratifying outcome by giving good tone to the system.

## THE RIGID OS IN LABOR.

BY A. A. LOVETT, M. D.

THE subject of rigid os in labor is ever fraught with interest, and one seldom sees anything printed on the subject that he is willing to pass by unnoticed—equally more is he interested in the subject when, called to a case of labor, he finds the condition present. He at once feels he has before him a long delay often of precious time, and an immense amount of suffering for his patient.

Our journals are full of varied experiences in these cases and one would feel there was, in the light of all there is written, little need for delay or anxiety, but nevertheless we find ourselves baffled time and again. Our remedies will help us out often, and that too very happily, but again the most studied case will resist in spite of all our efforts. I have but little use for the hot douche, as it removes from the vagina the mucous secretions so much needed for the easy expulsion of the fetus, and not only are they removed but the hot water contracts the mucous follicle and either diminishes or prevents further flow of mucus. I have frequently found an injection of hot water into the rectum of great advantage.

This must, however, be quite warm, and it is seldom that it is given warm enough to be of any benefit. It is not remembered that the rectal mucous membrane will bear greater heat than the skin. I have never used a rectal injection of chloral hydrate, not having found it necessary. I deplore the use of all medication directly and indirectly whenever the same can be avoided. There was a valuable expedient brought forward most forcibly by Dr. Winterburn a few years ago in this journal, and repeated so often that I would suppose no one who read his valuable series of articles on management of labor would ever forget it.

It will be remembered he dwelt upon it a great deal,

and surely it merited all he said. This was the free use of lard in the first stage of labor. Even in very ordinary cases it saves an immense amount of time to the physician and saves the woman a good deal of suffering. In these cases of rigidity of the soft parts he recommends the abundant use of lard. Even as much as one or if necessary two quarts during a single labor. It is recommended persistently and continuously, and the results will generally be satisfactory.

This may seem to many too simple and common—but I insist on Dr. Winterburn's method having a fair trial before anyone condemns it. At the same time there is no hindrance to the indicated remedy if you desire to use it. Your patient will soon express her gratefulness for the relief of the heat and tension of the parts with which it comes in contact.

The one great objection or hindrance to its use is the difficulty at all times of obtaining lard in a sufficiently solid state to permit of its application in the vagina. This is especially so in summer time. We cannot furnish it ourselves, nor can we have our patients feel the necessity of making the extra effort to procure the exact thing needed. It is impossible to place soft lard on the cervix with the unaided hand. I have almost been discouraged and was about to abandon its use for that reason.

Feeling, however, the importance of the matter and unwilling to give up a good thing, I procured a light hard rubber tube of three-quarter inch caliber, about seven inches long, with a piston of the same material, neatly finished so that I could render the same antiseptic. This holds about two ounces of lard when filled and is easily introduced into the vagina and the lubricant placed just where needed. I have it always in my obstetric bag, and it is an instrument I can little afford to be without. I feel safe in saying that with the free use of lard as indicated there need be but few cases of laceration of the cervix and perineum.

It is only a lazy physician who will read or sleep during these first trying hours of labor when much—very much can be done for the woman's comfort and safety. It is his highest duty to be constantly by her with such means as will secure her safe delivery. This is not meddlesome, as no force or violent manipulations are needed. I can relate many instances if necessary where my first examinations led me to think I had a long tedious labor before me. Cases that would have proved very tedious by such management as I had given in my early practice. The soft parts rigid—little moisture—and very hot. The woman nervous, irritable, and bearing her suffering badly. The free use of lard in just such cases has often worked wonders, and I have often been able to leave the woman safely delivered very much sooner than I thought it possible, with parts all intact and no rents or lacerations to invite septic infection.

I can see some of my severely antiseptic friends shrug their shoulders at the danger of conveying septic matter in the lard. But they can easily understand that if no lacerations, or abrasions are present there is little danger of infection. And, by the way, these frequent articles on extreme antiseptic management of labor seem uncalled for and unnecessary, when we can each of us remember numerous cases in our experiences, when women have been delivered surrounded by actual filth, and have laid in the same for days, and yet had an uninterrupted recovery. Even the most ordinary cleanliness was denied them. It teaches us this, that if the parts are whole—*i. e.*, no lacerations—nature will take ample care of our cases. To avoid these accidents is our first aim and highest duty. We may lose some distinction in having less brilliant surgery hereafter, but we have more nearly filled our higher mission.

## A PLEA FOR MORE CONSERVATISM IN GYNECOLOGY.

By C. B. KINYON, M. D.

**I**N a general sense conservatism is understood to represent opposition to sudden innovations. It may be, and perhaps sometimes is, looked upon as that element which is opposed to all progress. Of this latter meaning I shall not speak. It is admitted by all writers upon social and political ethics, that the greater the freedom enjoyed by the individual, by society, and by the state, the more need is there of the conservative spirit to hold in check that freedom, in order that it may not lead to unbridled license. Under these conditions the influence of conservatism is most salutary.

Applying these well-established principles to the science of medicine we find, as things are now constituted, more need of encouraging this spirit of conservatism in the New School than in the Old.

The traditions governing the Old School make that school the very embodiment of conservatism carried to its fullest limit of opposition to all progress. This is so manifest that little need be said regarding it.

With the New School the opposite tendency is growing upon us, and my purpose is to do what I can to check this tendency.

In order to reach the highest development we need the utmost freedom of individual opinion, and the broadest liberty of action. These coupled with an intelligent conservatism will give us an opportunity to reach the goal of our ambition, which is to place upon a solid basis the great law of cure.

As we are now situated we lack this stability as a school.

We are but human, and it is in accordance with human nature, as exhibited on all sides, to grasp at any, so called,

new idea. This idea is seized upon by enthusiastic minds, and, whether the idea was originally good or bad, there is great danger that the enthusiasm of the moment will carry us from our moorings.

The instinctive resistance of conservatism permits examination, discussion, and the putting to the proof, the ideas advanced by these enthusiastic minds.

This conservatism may delay progress somewhat, but this very delay is productive of good, for it gives time to separate the false from the true. And it is only upon truth that all beneficent progress can be based. Indeed, were it not for this conservative force innovations would be the order of the day. Unrealized hopes would follow, one after another, and universal unrest would take possession of the minds of men.

Nothing so retards growth and progress in any line of human endeavor as a well-grounded feeling of uncertainty.

With these few remarks of a general character, I will now proceed to make the application. I wish at this point to make it well understood, that in all I say I do not have in mind any men or set of men, but only principles and tendencies. I say this that all may know that nothing of a personal nature is in my mind.

We have in our own school two classes of practitioners that are, in the very nature of things, radical in their methods of thought and in their practice. Their radicalism puts us in a false light. In other words, their work retards true progress.

On the one hand are those, who, with an enthusiasm that knows no bounds, seize upon some new idea and almost lead us to think that the law of "Similia" is of no effect, or so limited in its scope that it is of little value as a guide to cure.

On the other hand we have those among us who, if allowed to guide us, would soon lead us to believe that by the law of "Similia" we can cure everything, and that there is nothing good outside of it. This latter class



would ask us to dwell forever in the realms of the unknown and the unknowable, discarding altogether the evidence of the five senses. These two classes are as opposite as it is possible for two extremes to be.

It is just at this juncture of affairs where the great conservative element comes into play, or does its work, so to speak.

It holds in check the two extremes. It sifts the good from the bad in both, and brings together in a complete whole the fundamental truths in each, and builds thereon the superstructure of homeopathy, the grandest and most beneficent system of cure yet formulated by man.

Let us turn our thoughts for the present to the work of the above mentioned classes in the field of gynecology. Both classes are properly termed radical. One looks at all cases as surgical in their nature, or rather as requiring surgical treatment for their cure. It matters not what the disease may be, or what pathological conditions may be present. Their only resource is surgery in some form. Of course they may differ as to the exact details, in method or manner of operation; but they agree in ignoring all attempts to cure by so-called therapeutic methods. Some are so radical as to advocate the entire removal of the uterus and its appendages at the first evidence of disease. Others begin with less radical measures, and if these fail to cure promptly the more radical measures are adopted without giving nature a chance to assist in the work of cure.

The other class is equally radical, only in the opposite direction. They use therapeutic measures only, often giving the highest attenuations; considering all resort to surgical or local treatment as barbarous and criminal.

Of the two classes it is hard to tell which is the most at fault. Certain it is that both have sacrificed many a life. The former class is very numerous, as it is found in all schools of medicine. The latter is not so numerous but it is aggressive. It is a hindrance to the advance of homeopathy, for it is confined to that school.

Need we wonder that we are often spoken of as theorizers, visionaries, and even as quacks. Those who see fit to so class us judge us by what these aggressive symptomatologists teach and practice. Can we blame them for so judging us? Our school as a whole has to suffer. "The innocent suffer for the guilty" the world over.

Speaking again of the class who operate too much, I will say this. They are governed by what seems to them logical reasons. But the trouble is they start out with a false premise. They reason thus: Pain means disease. This disease if not radically removed means such structural change that a cure is not possible. It is better, say they, to sacrifice a part than the whole. Better do this than to have a painful and incurable malady fastened upon a patient.

Then again they are impelled by the glamour of some new method of operating. Or may be they introduce some new operation, or modify some old one, and attach their name thereto. By one success they are moved to attempt the conquest of other fields; until at last they are impelled by that cruel master, *Ambition*.

When this stage is reached the Lord pity the afflicted who fall into their hands.

The other class is prompted by equally as sincere, but very different reasoning. They see in this class of diseases painful conditions disappear without operation. See many cases wherein actual structural changes are cured by nature, aided, or may be unaided, by therapeutic measures.

As this experience accumulates they become more and more convinced that the attenuated remedy is the cure all, and teach and practice accordingly. When cases die, they console themselves, and the friends, with the thought that we must all die when our time comes. I presume we have all been in places where we were willing and glad to hear people use this argument.

With these two extremes among us, each striving for the

mastery, there is still much for the rank and file, for the great conservative force to do in order to bring harmony out of discord, and to establish our school upon a solid basis of scientific knowledge. To so develop and perfect the application of the great law of "Similia" that our school will represent a stable equilibrium—a protection and a means of salvation of the afflicted from the thralldom of disease. To check these radical tendencies is the work of the conservative element of our school, and the best way for us to do this is to instill into the minds of all correct principles.

With the correct principles understood it will be an easy matter to place all the profession in such an attitude that false theories can find no soil in which to grow and produce dissensions within our ranks.

First in importance would I place the necessity of showing fully the influence which the pathogenetic bacteria have in the causation of disease within the pelvis and its organs and tissues. I put this first because of the seriousness and rapidity of their action, as well as the large number of diseases they produce. With their ætiological influence well understood and fully appreciated the treatment is readily mastered. With a knowledge of the deadly character of their work in mind, prompt and vigorous measures to neutralize their effects and eliminate them from the system, will be instituted in order to preserve the integrity of the tissues, to save life, and restore to health and strength. This can only be done by the thorough local use of antiseptics and by the removal of the products of their activity and their complete elimination from the system. Details for this work are well outlined in all the recent standard works.

Of course if this work is not properly done at the outset, their influence is so destructive that radical measures are often necessary to preserve the life of the patient.

It is in just this class of cases that the ultra-symptomatologists sacrifice so many lives by neglect.

The second principle in point of importance is the need of looking well to the circulation of the parts. Our success depends very much upon the proper blood supply in all diseases of the pelvic organs. The position of the patient and of the organs has much to do with the circulation in them. A correct conception of mechanical laws serves us well here.

Third in importance is the influence of drugs in the cure of these cases. I place this third, not because it is less important in the work of cure, but because drugs cannot do their proper work while either of the other faulty conditions obtain.

Do not for a moment understand me saying that with these three cardinal principles understood, and thoroughly applied, we can cure even every curable case. Far from it. For we will find many cases which will tax all our resources, and seemingly defy our best endeavors, yet will ultimately yield to well-directed, persevering efforts.

But I do say, and with emphasis, that with these principles well in mind we will avoid the extremes that are so productive of disastrous results. We will, at least, "do no harm."

One of these extreme methods is more destructive than the disease at the outset; while the other allows the disease to reach an incurable stage, when with the proper treatment it might have been easily cured.

In all cases the conservative treatment intelligently applied, at the proper time, will carry our patients along the road to recovery with comparative comfort.

In closing I wish merely to add, that, as we find it to-day, gynecology is the most unsettled branch of the healing art.

It is withal the most important, for upon its proper development depends not only the happiness of the afflicted of the present generation, but the happiness and welfare of future generations as well.

## CONGENITAL HYDROCEPHALUS.

By B. S. PARTRIDGE, M. D.

**C**ONGENITAL hydrocephalus is a true dropsy of the brain. It consists of an excess of cerebro-spinal fluid found within the ventricular walls, and is due to the development of inflammation of the lining of the ventricles during intra-uterine life. We shall not include under hydrocephalic disease those cases of arrested development of the brain, in which, a portion of the hemispheres being absent, an unusually large quantity of fluid is poured out to compensate for lack of brain substance; nor shall we speak of those cases in which the effusion is external to the brain, for this is believed to be secondary to the effusion within. We shall restrict our treatment to those cases of dropsy within the ventricular walls. The amount of effusion is sometimes small, while occasionally it amounts to several, even to ten pounds. The head is usually found enlarged at birth, and it continues to grow larger, and sometimes attains an enormous size, even to two feet in circumference. As the amount of fluid increases, the pressure from within gradually unfolds and flattens the convolutions, rendering the brain substance thin and attenuated. Where there is considerable enlargement of the head, the bones of the cranial arch, especially the frontal and parietal bones, become large and thin, the fontanels and sutures are wide open, and the interstices show decided fluctuation.

The forehead is prominent, and the roofs of the orbits are depressed, giving the eyeballs a downward direction. The cranial bones of a hydrocephalic head are deficient in lime, but contain an excess of organic elements in their constitution. Over the distended cranium the scalp is stretched tense and thin, its veins become prominent, and it is thinly covered with hair. Along with the increase of the head

are observed various trophic disturbances. The bones of the face are retarded in their development, presenting a striking contrast between the large skull and the small withered face. The visage takes the form of a triangle, with the apex at the chin. Emaciation occurs in the neck, trunk, and limbs, and the child becomes progressively feeble. It is not inclined to walk or use its members and it soon is unable to hold its head erect, and frequently has no power to roll the head upon the pillow. Defecation and micturition become involuntary. The digestive function finally is impaired and the child suffers from inanition.

So long as the cranium yields to distention and there is no compression of the brain, its functions are not disturbed ; but when the effusion becomes so great as to compress the brain, cerebral symptoms follow. The child becomes drowsy, and takes less notice of things. Convulsions often occur. Strabismus also is seen in some cases, and all the special senses may suffer. If the child live on for two or three years, the intellectual development is observed to be tardy and deficient. The sutures and fontanels finally close, but there is often no improvement in the child's physical or mental condition. Sometimes, however, after the disease has reached a certain stage, it remains permanent, or slight improvement takes place. Along with hydrocephalic disease are often found to co-exist other anomalies of conformation, especially spina bifida. This is but a part of the same disease. The spinal canal fails to close during fetal development on account of the large amount of cerebro-spinal fluid. Then, too, rachitis sometimes occurs with hydrocephalus, distorting the frame, enlarging the head, and destroying its symmetry. The diagnosis in most cases is not difficult. Enlargement of the head with open fontanels and sutures, the triangular visage and little old face, the downward direction of the eyeballs, the distinct sense of fluctuation, especially at fontanels and sutures, constitute the characteristic points



in diagnosis. In proportion to the amount of enlargement of the head will be the prominence of the above characteristics. Sometimes the head will be large at birth, occasionally so large as to necessitate puncture before delivery can be effected. But in many cases it is not possible to notice any enlargement before the first or second month. Vierordt says that the distinction between rachitis and "hydrocephalus" is made in the first place, by an examination of the nervous system, which in this disease is almost always injuriously affected (as respects its psychic, intellectual, and motor functions), while in rachitis it is normal; also the evidences of rachitis are to be sought at other points (the inferior maxilla, the thorax, the bones of the extremities). Moreover, we may have a combination of hydrocephalus and rachitic thickening of the cranium." All are agreed that the prognosis in this disease is bad. Most cases die in infancy or childhood. Yet there are evidences that treatment directed to the source of the effusion, and to the development and ossification of the cranium, has been followed by complete recovery. The following is a case from practice: In June, 1883, I was called to see Mrs. S. A., a farmer's wife, who was suffering from a protracted lochia. Five weeks before, she had been delivered of a hydrocephalic child weighing only one pound and a quarter. The physician who attended at delivery did not expect the child to live many hours. But here I found it, five weeks old, packed in cotton (for it was born at six and a half months), and having attained to a weight of one and one-half pound. Its head was much the larger part of it, and fluctuation was distinct in every part. The bones of the head were undeveloped and wide apart, and did not possess firmness enough to give form to the cranium. The mother failing to nurse, the child was fed diluted cow's milk, of which it took but little. I gave unfavorable prognosis for the child, assuring the family that it had "dropsy of the brain." The head continued to increase in size, and soon



ILLUSTRATING CASE BY DR. B. S. PARTRIDGE ON CONGENITAL HYDROCEPHALUS.

*January, 1897, Homeopathic Journal of Obstetrics.*



disturbance of digestion appeared, and it became necessary to change the food. I directed the mother to prepare and give the child sweet whey. Under this feeding the digestion gradually improved, although the vomiting and diarrhea would occasionally persist. For several weeks the child grew but little, presenting more and more the visage and characteristics of hydrocephalus. From the time of changing the food, I began a course of treatment with a view to control the effusion, and develop the cranial bones. The principal remedy relied upon was *calcareæ phos.*, occasionally changing to *arsenicum* or *cal. carb.* as a temporary expedient. We began to feed whey when the child was three months old, and gave it no other nourishment for ten months. In September it had several convulsions, and we despaired of saving its life; but after these ceased, the child began to thrive better, and show better nutrition. The head ceased to grow larger, but it was not until the age of two years that the sutures were closed. Finally we were able to substitute milk for its food, and after about three years, the child was enabled to walk. No untoward symptoms have since developed, and this patient is now a school girl of thirteen summers, in physical health, and with the intellectual faculties unimpaired. I regard this as a case of complete recovery from a disease of most unfavorable prognosis.

I will present one other case that came under my observation a few years ago, that is of considerable interest touching the complications, diagnosis, and prognosis of this disease. I photographed this case as I best could, taking both a back and front view. You will observe that there is a *spina bifida* in the cervical region (an uncommon location); also that *rachitis* has very greatly distorted the trunk, as well as the extremities. Although the history of this case was gathered from the parents, yet the evidence is clear that hydrocephalus existed at birth as is also evidenced by the *spina bifida* and the present appearance of

the head and face. This girl, Hattie N., was born January 14, 1873, and is now nearly twenty-three years old. She was a very small, weak infant, with normal head, save that the fontanels and sutures were open. The spinal tumor was tapped at five months, and injected with iodine. These injections were kept up at short intervals for several weeks, and were finally abandoned. During this time the head grew in size, and the bones were so soft that one side of the head and face became flattened from lying upon that side. (Observe how thinly the scalp is covered with hair). You will notice the deformity of the feet, and the contraction of the flexors of the left hand. She has good use of the right hand, with which she feeds herself. Defecation and micturition are involuntary, she has no use of the lower limbs, she cannot keep from falling over to the floor unless supported in some way. She is as helpless as an infant, and has the mental development only of a child of four or five years. She has a good appetite and digestion, and is well nourished. She menstruates regularly, this function having been established at the age of fifteen. Applying Vierordt's method of differentiating in the diagnosis of these cases, we shall be brought to the conclusion that rachitis and hydrocephalus co-exist in this person.



## ON THE MORE COMMON FORMS OF AMENORRHŒA, ASSOCIATED WITH MENTAL PERTURBATION. WITH ILLUSTRATIVE CASES.

BY GEORGE BURFORD, M. D.

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**A** FUNDAMENTAL law of development renders the feminine generative cycle peculiarly liable to error, when associated with mental perturbation. Amenorrhœa is the defect most commonly thus induced, and the associated psychological aberration acts chiefly through the emotional or through the intellectual centers. The former type, that of reproductive functional aberration from abnormal emotional stress, is the more familiar, as also the more evanescent. I will cite a typical instance :

A lady, aged about thirty-five, of spare figure and active temperament, and who for many years had been a martyr to dysmenorrhea, received a profound shock from the unexpected death of a friend. The mental stress was pitiable to behold, and was so intense as to manifest itself in extraordinary forms of the acutest grief. Apathy and lethargy by day, with recurrence of mental distress by night, gradually succeeded to the more severe phenomena of the earlier stage ; and for some five months onward a complete cessation of the regular period occurred. She had latterly indications of the menstrual nîsus in the shape of acute pain, but with no accompanying period ; and about five months after the last ordinary period she consulted me with a view to the rectification of the defect. Knowing the patient, as well as the circumstances of the case, with some thoroughness, I selected *ignatia* as the appropriate remedy. The effect was prompt and permanent ; the next period came on (with the former pain) in the usual manner, and has so continued up to the present. The happy surprise of the patient at the prompt issue was considerable, so much so



as to lead her to express a strong wish that the remedy should be more generally known as potent for such result.

Later on she again consulted me for another nervous phenomenon, the product of the same mental shock, in the shape of tumultuous palpitation awaking her during the night. For this lachesis was chosen, and with an issue similar to that recorded for ignatia. The cardiac neurosis very soon diminished and disappeared, and there has been no return.

From this case we deduce (1) that the amenorrhœa was the direct outcome of the emotional shock, and ceased so soon as the inhibitory effect of this was rectified by ignatia; (2) that the derangement of the menstrual cycle was, further, the outcome of *functional* perturbation of the emotional centers, and not due to any deep or essential trophic alteration in these centers, or those regulating the reproductive phenomena.

This case typifies the more common and frequent form of amenorrhœa concomitant with mental perturbation. Dating from a definite emotional shock, which acted as a deterrent on the menstrual function, this latter was readily re-initiated when the disturbing influence of the emotional stress was neutralized by therapeutic measures. These cases are the more frequent and the more easily curable; for it is to be noted that the menstrual function may be made to return even before the acuteness of the emotional shock has subsided. And the genius of the remedy here successfully employed—ignatia—is thoroughly in keeping with the view that emotional shocks engender functional rather than organic changes in the co-ordination of psychical and reproductive phenomena.

I will now proceed to outline a more complex case, where the emotional element in the induction of amenorrhœa was superadded, as a climax, upon antecedent psychical changes, these connoting more persistent and probably organic alterations.

A tall, well-developed girl, of slim figure and florid complexion, aged about thirty, had lived for some time a more or less secluded rural life, with an undue addiction to tea and a defective appetite. To attacks of facial neuralgia she had been latterly more or less liable; and the outcome of her unhealthy nervous condition was a disagreement with her family on matters of internal politics. In apparent caprice she transferred her energies to town, where she readily obtained a position as nurse-probationer in a large infirmary. Her mental disorganization was here completed, for, on being requested to pay the last offices to a dead body, her faculties became entirely unhinged, and it was necessary to transfer her to an asylum. The more violent phenomena of the crisis soon subsided, and in three months' time it was adjudged safe to send her under lessened restraint into the country. Unfortunately the mental irritability was too marked to allow this amelioration in environment, and it was soon necessary to transfer her again to the town institution. She continued for the next few months in much the same condition, and now, as heretofore, the dominant mental feature was an intense and persistent dislike to certain of her family and relations.

At the end of some eight months, seeing no further tendency to improvement, now that the more active symptoms had subsided, I advised her transfer to a district which combined the features of a hilly country with a rocky sea-coast, and which had the additional advantage of being her native air. Here, without observation or restriction, she spent some months in open-air life with no surroundings that were unpleasant or uncongenial, and far removed from the scene of her recent troubles. From this time improvement in her mental condition set in, and progressed until in about eight or nine months she was able to take an engagement as a lady companion. The employment consolidated the cure, and the only trace of her former mental crisis is a disinclination to address those friends who were responsible for her detention in the asylum.

During the whole period ranging from her removal to the asylum, up to some months after her transference to the sea-coast, complete amenorrhœa existed. As the mental condition improved the period returned, and finally resumed its normal and regular character.

I regret that during the period of her seclusion, no less than in the ensuing time, there was no opportunity of any sustained therapeutic management of the case. Pulsatilla, however, administered for occasional neuralgia, quickly afforded relief.

I now proceed to cite an instance where repeated accessions of mental perturbation took place with amenorrhœa secondarily induced. I present this as an instance of the reciprocal transference of disturbances in the psychical and the reproductive centers. The usual view, I am aware, is that such conjoint affection originates usually in the pelvic sphere. The ensuing case obviously displayed a converse inception, the aberration commencing in the psychical sphere, and secondarily engendering a block in the reproductive functions.

In 1892 Dr. Hawkes of Ramsgate kindly asked a single lady of about twenty-seven years with the following history, to see me. The period had commenced at the age of fourteen or fifteen, lasting each time some four or five days; it was never more than moderate, and had been regular up to the date of my first interview. In 1882 she had an accession of religious melancholia for some two or three months. At the end of this time it disappeared, and did not recur until ten years later. During the first attack no deviation was observed in the character of the menstrual period.

In 1892 another advent of melancholy supervened, lasting a few months, never acute, but sufficiently pronounced to cause her to suspend her duties, and seek solace in change of air and scene. The menstrual period on this occasion lagged and ultimately failed once or twice, but

under Dr. Hawkes' care both the menstrual depression ceased and the period normally returned. So things went on for another year, when in 1893 the unfortunate lady returned in all the throes of pronounced religious melancholy, with suicidal leanings. Complete cessation of the menstrual function now occurred during six consecutive months; and during the greater part of this time the mental distress was acute. A prolonged tour was made through England and Scotland in the hope that travel and variety might restore due proportion in the mental area, and various remedies, notably *pulsatilla*, *ignatia*, *aurum*, *nux vomica*, and some others, were assiduously administered. After about the fifth month of the amenorrhœa the mental stress showed some signs of relaxation, and the acute distress gradually and slowly subsided, until in about a twelve-month (and two years from its latest outbreak) most traces had disappeared, and the normal mental health had largely returned. Following the commencement of this improvement, the period returned, and regularly appeared in increasing quantity, until ere long its former duration and degree were again resumed. It is to be noted that the mental perturbation had become well developed ere the menstrual cessation supervened, and that the former had begun to show distinct signs of betterment ere the reappearance of the monthly period.

I have seen this lady quite recently, and it would be impossible to recognize in the alert, active, well-controlled woman of the present, the morbid, depressed, apathetic patient of the earlier time.

I watched the case carefully throughout, and my distinct impression was that the mental stress determined the amenorrhœa, and not the menstrual cessation the mental trouble. Her previous history confirms this view, for in 1882 she had a shorter but definite term of melancholy, with no concomitant amenorrhœa. The period occupied by the latest attack—two years—I have found paralleled in cases of post-influenzal origin.

In contradistinction to the foregoing, my next concrete instance will be that of a case where the psychical derangement commenced with the initiation of the reproductive life, and was intimately associated therewith.

Early in the current year I was asked through my friend Dr. Roberson Day to see a young girl who had recently been in seclusion in a large metropolitan asylum for a year. Her previous history, as narrated by her parents, was sufficiently striking. Menstruation commenced at twelve, and antecedent to this time she had been a bright, energetic, promising girl; but with the advent of the menstrual life a torpor seemed to neutralize the continuous development of the menstrual faculties. Her teacher now spoke of her as lazy, stupid, indisposed to mental work—a striking contrast to the promise of her pre-menstrual years. During this time—lasting for some years—she was more or less irregular, never, however, going more than two months without some show; menstruation would last four or five days, and was scanty and very dark colored. The chief hindrance to the mental faculties was most noticeable just *after* each period. She never had fits of any kind, nor was ever violent. So things went on, now more, now less promising, up to the age of two-and-twenty, when a sudden mental halt having occurred, it was decided to place her under restraint. In three months' time she had markedly improved, the mental cloud had dissipated, and she returned home relatively bright and hopeful. The type of menstrual life during this period of detention was as heretofore.

Just after Christmas of 1894 she again began to flag, and it was thought necessary again to transfer her to the care of the asylum authorities. During this period of detention she grew progressively worse, contracted dirty habits, and, after a twelvemonth, her parents had, at the request of the asylum authorities, removed her from thence, with a recommendation to arrange with a country institution for

further and probably permanent detention. According to the alienist her mental condition seemed to justify this extreme measure, and anxious to save their daughter from so dreadful a fate, the parents in their extremity consulted me. There had been complete amenorrhœa for seven months.

I found the patient a well-built, comely girl of medium height and florid complexion. She sat quite quietly, with downcast look or averted eyes, and though I could not elicit a word from her, she followed and responded by suitable gestures to my queries and requests. Curiously, each time she rose from her chair she would revolve in a circle ere making further movement, nor could persuasion or force hinder her from doing this. Her mental condition seemed dull, listless, and apathetic; she was in no way excitable, nor did there seem any active intellectual perversion. Her *tout ensemble* gave the impression of some restraining influence, like a cloud, hampering and fettering her mental and physical activities. Though said to have contracted dirty habits while in the asylum, I found, on local examination, no evidence of these, nor did careful local exploration reveal any organic abnormality or displacement or excess or deficiency.

In response to the anxious wishes of the parents, I determined to see what could be done with a diversified daily routine, and, above all, with appropriate therapeutics. My directions were that all red meats should be cut out from her dietary; that white meats and fish should be allowed but sparsely; that milk, cereals, fruits, vegetables, and fats should constitute the food stuffs; that she should spend as much time as possible, not less than six hours daily, in the open air, and that every attempt be made to interest her in out-of-door avocations. Finally, I gave her ferrum metallicum 6th, thrice daily for a month.

At the end of this interval her mother reported progress. To avoid prolixity, I may say that improvement was imme-

diate and progressive from this time onward. In less than three months the period had returned, thenceforward regularly and normally; and by another couple of months the mental perturbation had mostly ceased, the normal sprightliness and vivacity had largely returned, and the patient was in a fair way again to take up the duties of life. The contrast between the heavy, listless expression, the passive and torpid attitude, and the present active, lively, well-mannered girl seemed amazing.

To have achieved such a result as this in face of the bad prognosis given by the psycho-pathologists, and to have rescued a young girl from the horror of lifelong seclusion, anticipated as necessary by the asylum authorities, is, I take it, no mean achievement. While allowing fully for the accessory measures, I attribute the result mainly to the fine therapeutic workings of the drug *ferrum metallicum* in the sixth centesimal dilution.

These facts clearly typify a case where the detent was primarily the defective co-ordination of the reproductive life. Like the hidden half of a double personality, this element closely accompanied all the mental perturbations; nay, more, was definitely responsible for them, as a general view of the history plainly indicates. No similar condition, in even the least degree, characterized the remaining feminine members of the family; nor did mental instability appear, directly or collaterally, as a hereditary tendency. The pathological members of the series, from defect of the reproductive functions to defect of the cerebral functions, I cannot display; clinically, it suffices to show that where the defect is primarily of pelvic origin, the removal of this defect may promptly be followed by a rectification of the secondary cerebral aberration.

## NOTES ON UTERINE FIBROIDS.\*

BY EDWIN A. NEATBY, M. D.

OF the twenty-seven cases reported last year, ten of the patients are better; that is, improvement has taken place in their health through the lessening of hemorrhage and pain. In two of these ten cases, however (one a single woman aged thirty-one, and the other a married woman aged forty-four), the tumor has increased. In one case the general condition of the patient has suffered, without corresponding aggravation of the local signs. Three deaths have occurred, one after operation, one from apoplexy (?), one from bronchitis. Two operations were performed, one being fatal.

The new cases I record as fully as space will permit :

CASE XVIII. M. T. B., aged twenty-eight, single, came to me March 19, 1894, *complaining of menorrhagia* and weakness following the period. Excessive hemorrhage began when she was about twenty-one; came on quite gradually. She was under treatment during 1895, and at Christmas I curetted the uterus, which operation was followed by no improvement. Menstruation was profuse and occurred in gushes, worse when moving about. Hemorrhage was mostly bright, lasted five or six days, often eight or ten days of late. She had aching in the lumbo-sacral region and hypogastrium, lasting about seven or eight days altogether. She had many reflex symptoms, such as headache, depression of spirits, dreams, shortness of breath, and sensation of a "great hollow or empty space" in the chest, relieved by food. Bowels regular, no piles. Uterus was distinctly enlarged and hard, left ovary prolapsed and enlarged. Hydrastinin at first relieved the hemorrhage, but the patient continued treatment only at irregular inter-

\* London Homeopathic Hospital Reports.



vals. The last information I had was that she was much better after a long holiday.

CASE XIX. M. A. C., sent to me by Mr. Frank Shaw, aged forty-six, single, first seen June 11, 1895. Menstruation scanty, lasting three days only, and recurring every four weeks, was invariably accompanied at the beginning by "clawing and sore" pain in the hypogastrium and left iliac region. For the last seven or eight years she had suffered from *pain* (which "opens and shuts") *in the back*, severe and steadily increasing. The pain in the left iliac region came on when she walked, and was aggravated by lying on right side. Bladder relieved painlessly every ten minutes or less frequently during day, and three or four times at night. Urine of normal color. Leucorrhœa entirely absent. Bowels constipated, with occasional diarrhea. In previous September Dr. Lough had removed a tumor from uterus for hemorrhage (of six months' duration). Throughout these six months the hemorrhage had been irregular and almost constant. Vaginal examination (June 11) revealed the fact that the cervix was long, low, forward, and movable; the uterus was retroflexed, 3 to 3½ inches in length, the fundus being studded with fibrous nodules. The left ovary was prolapsed, large, tender, and adherent. In spite of these troubles the patient was gaining flesh. On her last visit (February 28, 1896) Mr. F. Shaw reported "great improvement, nearly free from pain, walking powers and general health both better." Treatment, aurum bromide throughout.

CASE XX. A. M. B., aged forty-nine, married twenty-nine years, came under my notice September 3, 1895. Had had two confinements and two miscarriages. After second confinement said to have had "abscesses of the womb," accompanied by discharge and pain which kept her in bed for two months. Four years ago she had first observed enlargement of the abdomen, and two years since was told that she had a tumor. A heavy and full pain had troubled

her in the whole abdomen and back for the last four years, which was increased by walking or lying long in one position. She complained of tired feeling. Her attention was first drawn to her abdominal trouble by "stoppage of the water"—it had to be drawn off two years previously; in general, micturition was not frequent during day, and about twice at night; if too long without passing it, she suffered occasional pain. Neither leucorrhœa nor hemorrhage was present. Bowels moderately constipated. The patient suffered pain in the right iliac region, lasting about three days, during menstruation, which was regular and of four days' duration; the pain was relieved by the onset of the flow, and increased by lying down. On examination a hard tumor was found in the middle line of the abdomen,  $2\frac{1}{2}$  fingers' breadth below the umbilicus, slightly nodular, and which moved with the movement of the cervix. A small mucous polypus protruded from the cervix, which was high in the pelvis. Treatment, merc. viv., and afterward aur. et kal. chlor. Result, general improvement.

CASE XXI. A. B., aged fifty, married twenty-five years, had had two confinements and three miscarriages; came to the hospital March 6, 1896, her attention having been drawn to her condition three months previously by pain in the right iliac, hypochondriac, and lumbar regions, lasting three days (the attacks being severe and of a few hours' duration) and greatly increased after food. Menstruation (lasting three days) was moderate, and recurred every four weeks, giving very little pain. Micturition, which took place every two hours daily, and once during night, was painless. Urine clear and scanty. Bowels were regular and natural. Urging was present when seen by Dr. Goldsbrough, who kindly transferred her to me. The patient was moderately well-nourished, losing flesh slightly. In the uterus a large, smooth fibroma was found, movable, extending up to within  $1\frac{1}{2}$  finger's breadth of the umbilicus. Cervix small, os patulous. Treatment, aur. brom.

CASE XXII. M., the wife of a medical man, aged forty-seven, had had no confinements and no miscarriages, came under my notice September, 1895, had aching pain in lumbar and sacral regions. Monthly period lasted five days, was free in quantity, especially during the last six months, reappearing every four weeks; twenty-four hours before its commencement patient suffered slight pain in the back, hypogastrium, and leg, which lasted two days. Bladder relieved five to six times daily, and twice during night; micturition was followed by aching pain which was worse at night. She had to wait before the urine would pass; it contained no albumin.

*Past History.*—Had had an attack of perimetritis five years previously; on the Continent during the summer she had another very severe attack of pelvic peritonitis (August, 1895).

The physical condition was as follows: A semi-pedunculated fibroid was attached to right side of the fundus, which could be felt as a hardish, irregular mass in the hypogastrium, extending to  $3\frac{1}{2}$  fingers' breadth below the umbilicus. The uterus was freely movable; hydro-salpinx was found on left side.

Belladonna and mercurius cor., followed by nux and sulphur, were taken for a month, and followed by much relief, especially to the backache. Aur. brom. was subsequently administered. My last report (sent by husband) was to the effect that the tumor was not increasing in size, and that the tubal condition was subsiding; backache was less.

CASE XXIII. G. S., aged forty-one, married, had had eight confinements and one miscarriage (at six months); first examined by me November 27, 1894, suffering from "gnawing, dragging" pain in right groin and down the right leg, worse at the monthly time; its duration varies. She had had three operations for "polypus." The first took place eight years previously, the second eighteen

months since, and the third one month before she consulted me. Since the last operation white leucorrhœa in moderate quantity and pruritus had appeared. Micturition took place three or four times daily, and once during night; painful only when polypus was getting larger, then suffered from dysmenorrhea. Menstruation profuse, watery, lasting seven days, recurring generally every four weeks, but sometimes continues for months together. Bowels constipated, no hemorrhoids. On examination the uterus was found enlarged, fundus above the sacral prominence, cervix much lacerated, left ovary prolapsed, and a small cyst in the broad ligament. Treatment, calcaria and aur. brom., and for hemorrhage, trillium.

CASE XXIV. E. T., aged forty-three, married eleven months, presented herself for examination March, 1896, suffering from pain in right side of abdomen and from hemorrhage. For five months she had had constant hemorrhage, with clots, which stopped when she was having hospital treatment. Menstruation (up to five months ago) had usually lasted eight days, reappearing every four weeks (before thirty years of age) and every three weeks since; it is free in quantity, bright and clotted. Since her thirtieth year the persistent pain in right side of abdomen and chest (formerly "sharp," and now "dragging down"), comes on one week before the monthly period (accompanied by sick headache on first day) and decreases after the first day's menstruation. This "tired" pain of which she complains lasts from seven to eight days. Leucorrhœa and bladder troubles are entirely absent. She has rectal hemorrhage, hemorrhoids, and constipation of the bowels. The patient is well nourished, and becomes "stouter" during the monthly period. In October, 1895, she had had a bad fall from a cart, followed in three weeks' time by hemorrhage. Examination revealed the presence of a hard, freely movable, uterine tumor, quite out of pelvis, reaching to within  $3\frac{1}{2}$  fingers' breadth of the umbilicus, a little higher

to the left side. Both ovaries were prolapsed. Treatment, plat. brom.

CASE XXV. The wife of a medical man, aged thirty-nine, married twelve years, had had five confinements (followed by no illnesses) and three miscarriages (last in June, 1895); came to me October 16, 1895, suffering chiefly from menorrhagia and general debility. For six months she had been troubled with dragging pain from the umbilicus which gradually increased every morning after rising; she also had pain in left hip. Menstruation usually lasted eight days, was very free in quantity, bright, with clots on second day, then "stringy"; at its worst on third day, had recurred lately every five weeks, formerly every four weeks, came in gushes during daytime, was accompanied by no pain. Leucorrhœa had started this year (1895), was acrid and free. Painless micturition occurred hourly each morning, and at intervals of three hours during the afternoon. Bowels irregular, tending to looseness with morning diarrhea, urgent in character; hemorrhoids during pregnancy and after monthly period, no hemorrhage. First symptom remarked by patient was menorrhagia after last confinement. A year ago (1894), she had discovered (while dressing) an enlargement above the pubes; the tumor was getting larger. Examination showed a fibroid extending to within  $3\frac{1}{2}$  fingers' breadth of the umbilicus, not tender, broad, extends well into iliac fossæ; both ovaries large, especially the left; left tube thickened. After a course of sulphur 12 and 6, the bowels became much more comfortable, the attacks of morning diarrhea practically ceasing. She took bromide of gold from November, 1895, to April, 1896; no increase in size of tumor had taken place at this date, but in spite of helonias and trillium the hemorrhage remained the same, secæle in doses of *mv.* to *x.* moderated the loss. Though the tumor had ceased to grow, the excessive hemorrhage left the patient, if anything, weaker than in October last.

CASE XXVI. E. C., aged forty-three, married twenty-four years, had had three confinements (last one seventeen years previously) no miscarriages, had suffered from aching pain in left groin and thigh to knee for one year. Menstruation, which since marriage had been painless, was profuse from the onset, lasted five days, and recurred every four weeks. Patient had had "ulceration" and leucorrhœa sixteen years previously, but the latter was now absent. At the present time bladder was relieved from three to four times daily, and not once during night. Two years previously micturition had taken place sixteen to twenty times daily (lasting about one year) and was relieved by pressing the tumor up; but throughout the urine had been passed painlessly. Bowels regular and natural, hemorrhoids. Patient's general condition was good, neither gaining nor losing flesh; her abdomen was swelling. *Her first symptom had been pyknuria.* The tumor was discovered  $2\frac{1}{2}$  years previously, and had grown only slowly. Examination of abdomen revealed the existence of a large nodular fibroid; movable semi-pedunculated masses projected from the surface of this on both sides of the middle line, the highest level was two fingers' breadth below the umbilicus, cervix jammed to the left; a large projecting nodule, to right of cervix, reached to within two inches of vaginal orifice. In March, 1896, a soft swelling like a dilated tube was found in Douglas' pouch; the tumor reached to within half a finger's breadth of the umbilicus. The chief remedies were aur. brom. and platinum together with trillium for the hemorrhage, which was considerably moderated. The treatment was repeatedly interrupted by medication for "fidgets," palpitation, and other reflex symptoms.

CASE XXVII. R. G., aged thirty-nine, married twenty years, had had two confinements (last one ten years previously) preceded by two miscarriages; after the first miscarriage she had had "internal inflammation"; came for examination March 11, 1896. She suffered from pain in the

left side and in the rectum, which dated from the first miscarriage; it was steadily increasing and always worse at the monthly period. Menstruation always excessive, lasting seven days, and generally reappearing every three weeks, occasionally after an interval of only fourteen days, was bright, clotted, and offensive. Seven days prior to the commencement of the monthly period severe aching pain sets in, in the left lumbar region and groin, extending down the left thigh, lasting eleven days. Patient troubled with constipation of the bowels and hemorrhoids. The uterus was larger, heavy and retroflexed, fundus was hard and nodular due to commencing fibrosis, right tube was thickened and right ovary enlarged. Paladium was prescribed; some relief was obtained, but not enough to enable the patient to get about her work comfortably. Removal of the appendages was performed on May 23, from which the patient made a tranquil recovery.

CASE XXVIII. O. M., aged thirty-eight, had had two confinements, was examined by me March 29, 1895. Her attention had been first called to her condition by profuse white leucorrhœa, which had continued for the last  $2\frac{1}{2}$  years. For nearly five years menstruation had been very profuse for the first two days, scanty after, lasting in all nine days, recurring every four weeks. It was attended by burning pain in right iliac region, which appeared on the third day, and lasted from four to thirty-six hours. Micturition painless, increased during night. Patient first felt "lump in abdomen" fourteen to eighteen months ago. Examination revealed a fibroid extending to within 1 or  $1\frac{1}{2}$  finger's breadth of the umbilicus, involving chiefly the anterior wall of the body, almost entirely extra-pelvic. Cervix not involved. Treatment, aur. brom., and secale 3x, when required for pain. On April 1 menstruation and pain had both diminished, on April 22 platinum was prescribed.

CASE XXIX. C. S., aged forty-nine, married at nine-

teen, had three confinements (followed by no illness or flooding), last one occurring seventeen years ago; came under my notice July, 1895. For the last five or six years she had been troubled with hemorrhage, and a sharp pain in the left iliac region, occasionally shooting down leg or groin, which was steadily increasing during the last two years. Menstruation, accompanied by slight pain and recurring every four weeks, was of from five to six days' duration; for two days of the period it was profuse, dark, and thick. Two years previously I prescribed hydrastinin. She had suffered from persistent leucorrhœa after the monthly period for four or five years past. She micturated painlessly three to four times daily and once during night. Urine of good color. Bowels constipated, but relieved naturally; hemorrhoids and occasional hemorrhage. Patient was not pale, but losing flesh. Examination showed uterus hard and central, extending up to within  $1\frac{1}{2}$  finger's breadth of umbilicus; cervix central, not much encroached upon; left ovary is low and adherent. Treatment, aur. brom. Reports improvement.

CASE XXX. B. P., aged fifty, single, came for examination, February 7, 1896; since October had been suffering from cramp-like pain all over the abdomen, which is steadily getting worse. Throughout the monthly period (lasting from four to five days) she has "dull, heavy, severe bearing-down" on the left side of abdomen. The flow is bright, in clots and free in quantity. Since she was forty-five years of age it has recurred every three weeks, and about three or four days before its commencement the pain appears. For some years she had been under medical treatment for internal troubles, was said to have "ulceration." Examination disclosed a fibroid growing to within one finger's breath of the umbilicus in the middle line, higher to the right. Cervix was movable and situated under pubic arch. The growth was all extrapelvic, and very tender on the surface. Treatment, nux. vom. and trill.



CASE XXXI. E. O., aged forty-five, single; came under observation April 30, 1895. Menstruated every four weeks painlessly and profusely, lasting from seven to twelve days. It had been profuse for ten years. She was very anæmic, and had become thinner. Five years previously she had noticed her abdomen to be enlarging. On examination, a hard nodular tumor was found projecting down into the pelvis, and reaching on the right side to the level of the umbilicus; on the left it was not quite so high. The ovaries were not felt. Bowels were regular, she had moderate bland leucorrhœa, worse before the period. For a few weeks she had suffered from pain in the right side of the tumor, which was relieved by rest. She was under treatment for the remainder of the year, taking chiefly aurum bromid.; for the hemorrhage she had trillium, crocus, and secale. As long as she kept about there was no improvement, and in September she suffered severely from loss of blood, having palpitation, vertigo, and tinnitus aurium. In November and December she was obliged to keep her bed on account of hard, painful swelling on the lower extremities, first one and then the other; the calf was chiefly involved. This was apparently due to the blocking of the deep veins. As the patient was very anxious to return to her daily work, on which she depended for her livelihood, it was decided to remove the tumor. On January 28 the abdomen was opened, the tumor removed without difficulty, and the pedicle treated extra-peritoneally. The first week the patient did uninterruptedly well, and was removed from the special to the general ward; convalescence was subsequently disturbed by an attack of pleurisy. She left the hospital in excellent condition on April 7.

CASE XXXII. May, 1894. R. W., aged twenty-eight, single. Menstruation free from onset at eleven years; usually eight or nine days. Latterly gradually more in time and quantity. There was severe dysmenorrhea com-

ing on with the flow, the pain affecting chiefly the abdomen (hypogastrium) and legs. Accompanying menstruation is nausea, and during the first day a tendency to diarrhea. There was no leucorrhœa. The vaginal orifice was very small; the examination, therefore, was limited to the rectal route. The uterus was large and freely movable, cervix pointing strongly backward. The right ovary was felt as a tender elastic body in Douglas' pouch. This patient was a nervous and intellectual woman, a hard student and a bad sleeper. While under my care and studying for an examination, she held her ground; the hemorrhage not becoming more severe and the sleep improving. She took phosphorus, hydrastinin (Merck), and platinum. After her examination was over and her mind easy, she relaxed her care and I lost sight of her. I heard the hemorrhage had got much worse and she had been taken to a specialist, who removed the uterus and appendages. The pedicle was treated extraperitoneally, and the patient made a good recovery.

CASE XXXIII. F. A., kindly sent to me by Dr. Blackley, aged forty-nine, married twenty-seven years. Had had five children, the last eighteen years previously. She had had no illness after her confinements, but had an "attack of internal inflammation" after a miscarriage seven years ago. Her chief trouble is abdominal pain ("like inflammation") and distention. She was unaware of the existence of the tumor, which on examination was found to extend nearly to umbilicus. Menstruation is moderate, somewhat painful. Tendency to retention of urine. Bowels constipated, relieved by aperient, no hemorrhoids. Took bell. and merc. cor. and calcarea iodata.

CASE XXXIV. S., aged forty-two; first seen May 27, 1896. For last four or five years had suffered from dragging pain in sacral region and in chest which was increasing.

Menstruation moderate (formerly free), pale and thin, recurring every three weeks. Bowels relieved daily, piles with hemorrhage.

Patient is moderately nourished; the abdomen is enlarged, and increases at each monthly period. The legs swell and are painful. Nine years ago patient first felt pain in abdomen, and her examination discovered a tumor.

A large fibroid was found extending beneath costal margin on left side, and quite up to liver on right.

Her chief complaint is of the weight of the tumor; she has also varicose veins in the legs which ache a good deal. Iodide of lime was prescribed.

*Remarks.*—In the present series of cases two patients came under notice at the age of twenty-eight years, and one of these had probably had her tumor some one or two years. The rest of the patients varied from thirty-eight years of age to fifty, and they had practically all begun during the last decade of sexual activity. This was also very strikingly the case in my last year's cases. The two cases of younger women this year were both single, and last year the same was evident—the women developing tumors between twenty-five and thirty years of age were unmarried. Further recorded experience is required before the converse can be stated as true—"young women who marry and have children do not develop fibroids." Still the last ten years of sexual activity must be regarded as an ætiological factor in the history of fibroids.

Six of my patients were single women, making a total of ten out of the thirty-four—two of these were young women. The chief pelvic troubles of single women who come to the hospital are dysmenorrhea and fibroids. The relation between fertility and fibroids is still one demanding a further study and a large accumulation of cases. Of my last series only two married women had had no pregnancy; the others had had from nine to two, giving an average of almost four to each mother. Except in two instances where fibroids developed, child-bearing ceased before thirty years of age. A much larger proportion of the second series bore children, raising my average to 2.7 per

head—one still a good deal below the average fertility of married women. This is probably not a greater diminution of fertility than any other disease would show.

Respecting hemorrhage, ten out of seventeen last year and ten out of seventeen this year had menorrhagia—a total of twenty out of thirty-four. This, then, constitutes the leading symptom as a rule; but this is by no means always so; even where present it may be overshadowed by other symptoms; neither extreme of life seems specially to affect the hemorrhage. Wherever it is started a vicious circle is set up; the increased blood-supply to the pelvis increases the nerve or ovarian nutrition, and by this means defers the menopause for five years or more. Where the ovaries of women with fibromyomata of the uterus are either seen or felt, they usually appear enlarged. One interesting fact I have noted is that of a woman aged forty-three, who had a tumor which must have been present, from its size, at least three years, and from the symptoms probably much longer. When she came to the hospital she had been married eleven months. For more than half that time she had had almost constant hemorrhage, ceasing to some extent from rest. Here the stimulus of married life may be supposed to have aroused a dormant ovarian activity, and to have roused the tumor to fresh development.

Finally, after twelve months' further experience as to treatment, I speak with more confidence as to the efficacy of medicinal measures. The drug may act through the nervous system by inhibiting the nerve action on the ovaries. For those who prefer indefinitely to lie up it is not commonly necessary to operate. The advice of German and French gynecologists, however, is more in favor of operation. Ovarian irritation may be removed by the knife (removal of appendages). Two of my patients, unable to rest thoroughly, underwent removal of the appendages. It is too early to speak of final results. Of three hysterectomies, one was fatal.

The choice of drugs lies between antipathic ovarian sedatives, *e. g.*, bromide of potassium, and homeopathic drugs given with a similar hope, *e. g.*, ovarian irritants, colocythus, aurum, platinum, calcarea iodata, etc.; between vascular sedatives, secale, trillium, helonias, and ergot, in large doses.

A gratifying, and often unexpected amount of relief frequently follows the exhibition of remedies, especially where rest can be combined with treatment by medicines.

The usefulness of curetting is more than doubtful when there is no accompanying endometritis. Harm may easily be done by this means. The "tissue" remedies I have reaped benefit from are aurum, calcarea, platinum, etc. There is, however, much scope for carefully selecting the simillimum to these cases; often collateral troubles, such as pain, difficulty of micturition, diarrhea, etc. For these medicines are very often successful.

## SYMPOSIUM UPON LOCAL APPLICATIONS AND THE USE OF ANÆSTHETICS DURING LABOR.

BY VARIOUS AUTHORS.

### What local application use in labor?

Forty answer none; six, belladonna; five, lard; four, hot water; four, vaseline; two, sweet oil; two, cocaine; one, petroleum.

Pure lard or oil, warm and smeared on the parts freely.—

*Dr. G. Forrest Martin.*

Belladonna and cocaine tampons.—*Dr. Alex. Berghaus.*

Sweet oil, lard, and vaseline.—*Dr. T. J. Jones.*

Oil only.—*Dr. J. F. Smith.*

Hot water.—*Dr. W. B. Robinson.*

Hot water. Am careful to avoid extract of belladonna,

as I fear post-partum inertia as a consequence.—*Dr. G. E. Tytler.*

Ung. bell. to cervix.—*Dr. M. D. Youngman.*

Belladonna tampon at os uteri.—*Dr. Wm. I. Tyler.*

Petroleum or lard.—*Dr. F. D. Brown.*

None, except steaming with hot napkin.—*Dr. Chas. L. Nichols.*

Sometimes paint with extract of belladonna and glycerin.—*Dr. J. K. Sanborn.*

Lard or vaseline, but prefer lard.—*Dr. J. T. Thatcher.*

None for dilatation ; Pond's extract after delivery.—*Dr. O. S. Wood.*

To the perineum I employ hot water fomentations.—*Dr. J. M. Smith.*

Use no local application but clean water to bathe the parts externally. Sometimes when there is extreme sensitiveness use a weak solution of arnica or calendula when tissues much bruised.—*Dr. S. H. Knight.*

Have not found any useful.—*Dr. Wm. D. Foster.*

In extreme cases extract of belladonna.—*Dr. H. E. Beebe.*

Sometimes use local application of two per cent. solution of cocaine on cotton.—*Dr. W. M. Bailey.*

### What injections are used ?

Forty answer none; eleven, warm water ; two, bichloride ; one, boric acid ; one, carbolic acid ; one, calendula.

Hot water with glycerin.—*Dr. Spranger.*

Hot water douche.—*Dr. Edwin Smith.*

Boiled water only, unless some foul or septic matter is present, then calendula or boric acid or carbolic acid solution.—*Dr. G. Forrest Martin.*

Hot water.—*Dr. Mary Branson.*

Oil only, if evacuations have been had freely.—*Dr. A. J. Smith.*

Hot water.—*Dr. Wm. I. Tyler.*

Douche of bichloride, 1-4000.—*Dr. R. Kingsman.*

None; if any at all, calendula and hot water.—*Dr. J. T. Thatcher.*

None, as regards dilatation; Pond's extract, bromochloride, or Platt's chlorides, after delivery.—*Dr. O. S. Wood.*

Before the advent of labor one douche of 1-4000 bichloride; none after.—*Dr. J. M. Smith.*

I never use an injection except after forceps delivery, when I use one to wash out all clots or debris, and then let the patient's parturient canal severely alone.—*Dr. S. H. Knight.*

Hot water for cleanliness only.—*Dr. Wm. D. Foster.*

I rarely use any, relying upon internal medication for any morbid symptoms, but sometimes an injection of hot water, slightly medicated with tincture of myrrh, is beneficial. Tincture of myrrh is one of the best local applicants we have for almost anything.—*Dr. A. W. Cushing.*

Hot water per rectum.—*Dr. H. E. Beebe.*

Rectal injections if necessary to relieve impaction.—*Dr. Geo. M. Ockford.*

Usually none. When needed for cleanliness, warm boiled water.—*Dr. O. A. Watson.*

**Is anæsthesia employed?**

**In what per cent. of cases?**

**What anæsthetic preferred and why?**

Forty-nine answer yes; three, no. The percentage running, one, 1 per cent.; three, 2 per cent.; one, 4 per cent.; three, 4 per cent.; three, 10 per cent.; one, 15 per cent.; four, 20 per cent.; three, 25 per cent.; one, 30 per cent.; one, 40 per cent.; four, 50 per cent.; one, 70 per cent.; three, 75 per cent.; one, 80 per cent.; five, 90 per cent.; one, 100 per cent.

One uses it occasionally; two, rarely; three, seldom; four, sometimes.

Forty use chloroform ; six, ether ; four, A. C. E.

Chloroform during pains only.—*Dr. A. J. Smith.*

Always if forceps are applied. Sometimes at close of second stage, if pains are agonizing and patient holds them back. Just enough to relax, not complete anæsthesia in such cases. Chloroform. Quickest in effect, and pleasant. Does not leave house saturated as ether does.—*Dr. G. Forrest Martin.*

Chloroform, in nearly all cases. It is entirely safe in labor, if wisely given.—*Dr. Alex. Berghaus.*

A little chloroform in most cases to deaden the pains a little ; ether for complete anæsthesia.—*Dr. T. J. Jones.*

Ninety to ninety-five per cent. Chloroform generally ; during pains only. I prefer chloroform as being safer with reference to any possible kidney involvement, and producing anæsthesia more quickly.—*Dr. M. D. Youngman.*

Only in eclampsia and for some operation as turning. I should judge in from two to five per cent. Chloroform, as it is more prompt in relaxing the parts.—*Dr. E. J. Jones.*

Chloroform, straight, is preferred owing to its quick action and less liability to produce nausea later. It is used in latter part of second stage only, when head impinges on perineum.—*Dr. A. L. Fisher.*

Chloroform, more rapid to use and to recover from, and greater dilatation.—*Dr. T. D. Brown.*

A. C. E. Mixture. Alcohol, chloroform, and ether, more prompt, less nausea.—*Dr. A. H. Tompkins.*

A. C. E. Mixture. It is safer than chloroform, and this is important because cannot give anæsthetic undivided attention. I use it toward the end of the second stage, and find women are very susceptible to surprisingly small quantities of the anæsthetic.—*Dr. W. D. Bayley.*

A. C. E. Mixture. Pleasant for patient to take and the alcohol is heart-tonic.—*Dr. Lamson Allen.*

Only in forceps cases, when I use ether, because safer for some friend of the family or husband to handle.—*Dr. F. P. Batchelder.*



Chloroform, less dangerous to kidney, not so much required.—*Dr. J. Kent Sanders.*

In about four per cent., particularly primipara. Chloroform; rapid in its action and patient recovers quickly from its influence; proven a safe anæsthetic for obstetrics.—*Dr. J. M. Ward.*

To complete narcosis in a very small per cent. of cases. But nearly every case has been partially under the influence of an anæsthetic. Chloroform preferred, because of its rapid action, safety, and efficiency.—*Dr. C. B. Higbee.*

Never had occasion to use anæsthesia, only when forceps delivery is necessary.—*Dr. R. Kingsman.*

In nearly all in last stage of labor. Chloroform and chloroform and ether 1 to 3 to ease the pains.—*Dr. J. T. Thatcher.*

Not often, and then in last stage of labor only. A very *small* percentage, indeed. Chloroform. It is pleasanter than others and acts quicker.—*Dr. O. S. Wood.*

Rarely, except in instrumental work, about ten per cent. Chloroform; I esteem it safer during pregnancy, to my mind less injurious to kidneys, and less offensive in odor to patient.—*Dr. J. M. Smith.*

Unless the patient objects always offer a few whiffs of chloroform during last severe pains. Probably nine-tenths of the cases are glad to dull the last severe pains by a few breaths of chloroform. Always with forceps cases. I use chloroform always in preference to ether when using an anæsthetic for any purpose, unless there is some special contra-indication. I use chloroform because it is easier to put the patient under its influence and the after effects are not so disagreeable.—*Dr. S. H. Knight.*

If necessary in the very last stage, sometimes sent for chloroform and finished before its arrival (moral effect?). Very few. Chloroform, from habit—easily administered.—*Dr. A. Berghaus.*

Chloroform. It is more prompt and effectual and does

not disturb the stomach as much as ether or A. C. E. mixture.—*Dr. E. E. Reininger.*

Prefer chloroform because it is quicker in its action and the results have always been satisfactory.—*Dr. W. M. Bailey.*

If patient requests it. About once in four times. I use chloroform; it causes no nausea.—*Dr. Kate L. Hickox.*

Only in cases of dystocia, when eclampsia threatens, or the forceps are to be used. Not more than two per cent. Ether, because I consider it safer.—*Dr. R. D. Wilson.*

Chloroform; experience has proved it both safe and efficacious. Ether dangerous to kidneys.—*Dr. R. N. Foster.*

For many years I used chloroform, an ounce or two ounce vial one-half full, held to one nostril, the other free. During the pain only; not enough to produce anæsthesia or affect the pulse, but it will ease the pain. Of late years I have used nothing but amyl nitrite. I first used amyl nitrite when I was attending a young lady, with first child. She was tall, slim, narrow pelvis, promising a tedious labor. I placed my forceps under the bed and at the proper time introduced one of the blades, the patient lying on her side. When I was ready to place the second blade she said, "If you are intending to use those instruments you must give me something." To my surprise I found I had neither chloroform nor ether, so took from my emergency case a vial of dilute amyl nitrite, and ordered the nurse to let her inhale it, which she did and without a word of complaint. Suffice it to say that since, in many hundreds of obstetric cases, I have found it equally satisfactory. I usually use one part to three or four of alcohol.

I give the following additional confirmation of this remedy's usefulness: A lady went to a specialist in female diseases, living in Boston. She received lots of medicine and electricity—paid fifteen hundred dollars for thirty weeks' treatment, and came home to die. I was called to see her. I will simply say she had fearful uterine pains every other

day, at 4 P. M. I gave her belladonna in water, and left amyl nitrite to inhale during the pain. The next afternoon she had slight pains, soon relieved, and in ten days was helping her husband make the garden. In the same family was a young lady of twenty-five, that suffered untold agonies at every menstrual period. When it appeared she started for her bed, saying, "If I could only die!" The lady offered her the little vial of amyl nitrite. In the night she awoke with her usual agony, smelled the amyl, and went to sleep, and in the morning said Dr. Cushing should have a chromo; before night she changed to an oil painting. Avoid using it stronger than 1 to 3 or 4, for it will produce severe headaches.—*Dr. A. W. Cushing.*

Very seldom, and when it seems to be the lesser evil. The smallest possible, not over ten per cent.—*Dr. R. Hughes.*

Chloroform; because one or two deep inspirations when pain is on are sufficient, it acting more quickly than others.—*Dr. O. A. Watson.*

Chloroform; because the stage of normal labor seems to be adapted to the use of chloroform.—*Dr. H. E. Beebe.*

All cases, unless rapid and painless. Chloroform: Less trouble: No accident for twenty-two years.—*Dr. A. R. Harris.*



## APPLICATION OF THE FORCEPS.\*

TRANSLATED BY B. F. UNDEROOD, M. D.

(Continued from p. 575, November, 1896.)

**T**HE first, right, notched, branch. Guided by the left hand. Held in the right hand.

Introduction of the guiding hand. The left hand is to be introduced in the usual manner, since the first blade, the posterior, to which it is to act as a guide, is the right. To reach the ear, which at this time is lateral and posterior, the entire hand, including the thumb, is to be carried backward and to the right between the coccyx and the right ischium.

When the entire hand has been introduced, so that the vulva embraces the wrist, the neck of the uterus will have been passed and the ear, before which the blade should come and rise above the lobule to embrace the malar bone in its fenestra, may be easily found.

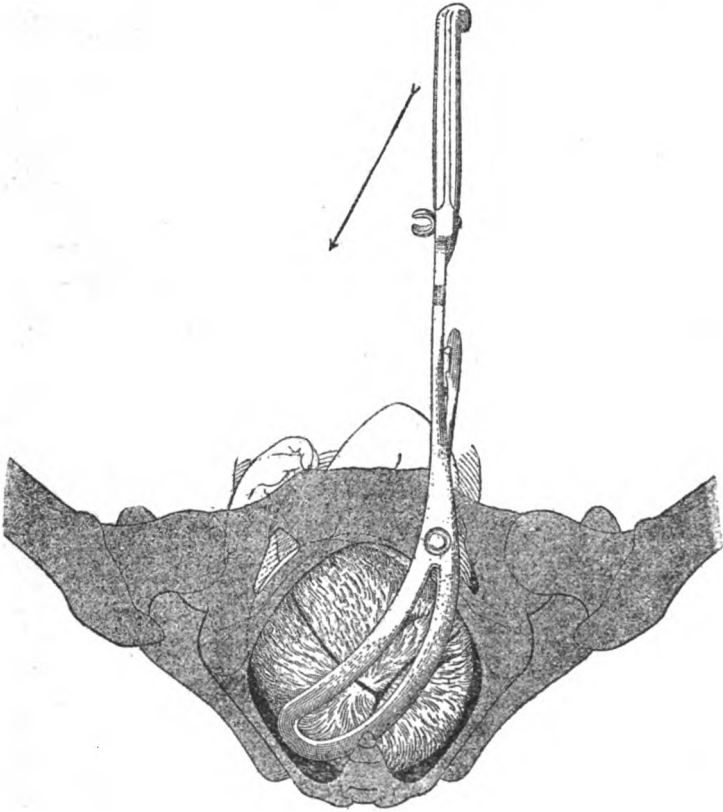
To be well placed the guiding hand should have the ear beneath the ring and little fingers, the ends of the fingers passing above the lobule. This being done, the other fingers, applied to fetal temple, will cover the parieto-malar line, the line of application, and will properly guide the blade and effectually protect the maternal canal.

Presentation, introduction, and placing of the blade. When, and only when, the guiding hand has been properly placed, the right blade is to be introduced and placed: blade in the axis of the guiding hand, the handle raised at the beginning, the hook lowered obliquely to descend outside of the left forearm. This is a repetition of the movement made in the introduction, secondly, of the same right blade in the preceding application. But in this case the blade will be properly placed at the outset. The hand will

\* From the French of Professor Farabeuf and Dr. Varnier.

now be withdrawn and the blade allowed to rest upon the fourchette.

**Fig. 45.** Vertex at the inferior strait in the occipital left posterior position. Presentation of the first, the pos-



**FIG. 45.**

terior right blade, the handle raised a little to the left of the median plane. The blade will enter backward to the right, properly placed at the outset if the hook is lowered in the direction of the arrow, obliquely, parallel to the meridian of application.

The handle of the right blade properly placed is slightly raised, nearly horizontal, lightly turned toward the right of the mother; its hook which, at right angle to the taking surface of the blade, the guide to its position, is raised above and to the left. This attitude will be evidently the same, except for a little greater elevation of the handle, if the occiput were in front instead of the forehead and *vice versa*, Fig. 46.

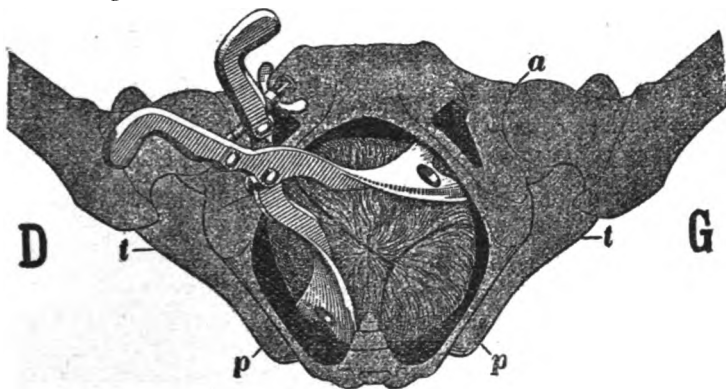


FIG. 46.

Fig. 46, vertex at the inferior strait, in occipital right anterior position.

The handle will be intrusted to an assistant, kneeling at the right, who will maintain it immovable.

Second, pivoted, left, branch. Guided by the right hand. Held in the left hand.

Introduction of the guiding hand. For the second blade, the left, the right hand becomes the guide. It will be introduced, without the thumb, backward and to the left as far as possible, until it is arrested by the commissure of the thumb; thus it will have passed the neck of the uterus. The way made, the junction of the sagittal suture and the posterior fontanel may be felt; finally the palm of the hand will embrace the occiput, the fingers reaching to the neck.

Presentation, introduction, and placing of the blade. Upon this right guiding hand, properly placed and knowing where it is, the blade is to be introduced and entered along its axis.

Let the handle of the hook which is above lower itself obliquely along the border and outside of the right forearm. Do not count upon a profound penetration of the blade, for the beak will reach the neck quickly enough and the resistance experienced and particularly the indications of the guiding hand should be recognized and regarded.

The penetration possible and necessary having been obtained, remember to bring the blade first on the side, on the mastoid region, but a little more forward, above the ear. The space into which it is to go is to the right: the guiding hand should conduct it carefully into place without disturbing the head and risking its displacement, and disturbing the position of the first blade and badly placing the second. Of itself, it will glide easily only when it is in contact with the convex surface of the fetal head.

It is necessary, as always, in making the movement of Mme. Lachappelle, to know what is to be done and to do it with one hand easily and lightly, without force.

To bring about the gliding movement necessary to bring the blade from the position of introduction, left posterior, to the position of application, left anterior, use the handle. Fig. 47. This is still upright, the hook *G* directed obliquely upward and to the right the same as the taking face of the blade. When the penetration is sufficient (it has not been made in Fig. 46) the handle is a little removed and to the left of the median plane. Then the handle is lowered, brought to the right of the mother and the hook turned, to make its direction at first tranverse: the blade passes on the side, first step.

Pressing it forward always to favor the penetration of the blade, the hook is lowered considerably and turned anew in  $45^{\circ}$  to bring it directed downward and to the right: the

blade slips over the ear and passes on to the parieto-malar line, to the right of the ileo-pectineal eminence, second and last step. But the handle will be too low to cross the first blade in the proper position. It is necessary to uncross them.

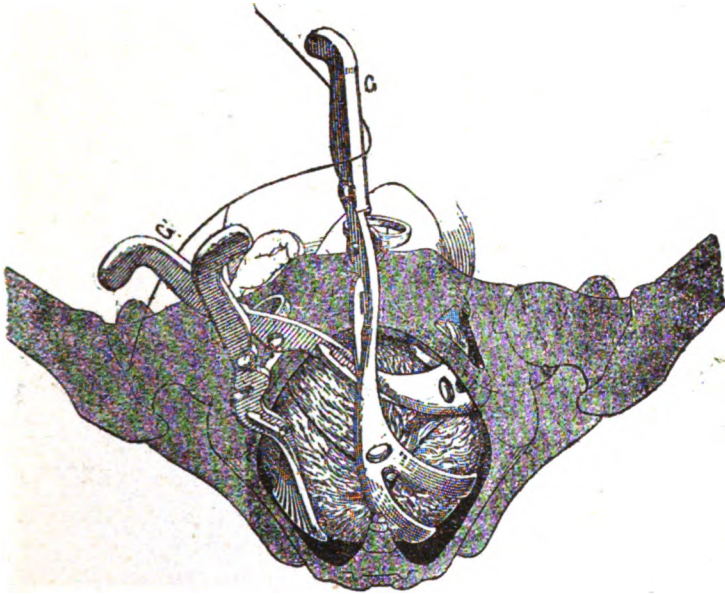


FIG. 47.

Fig. 47. Vertex at the inferior strait in the left occipital posterior position. Introduction and placing of the second blade, the left. It has penetrated backward to the left, by lowering the handle obliquely, but quitting the occiput it jumps the ear and gains the cheek, forward to the left, by moving, turning and lowering the hook G. The pivot crosses above the notch so that articulation is not possible until the handles have been uncrossed and brought into the proper position.

#### ARTICULATION OF THE BLADES.

That articulation may be possible, it is necessary to uncross and recross the handles in such a manner that the



notched blade will cross above the one having the pivot.

This maneuver requires some yielding upon the part of the vulva with primipara, and it must therefore be made slowly and without force. In making this movement the posterior blade, the one first placed, and consequently ap-

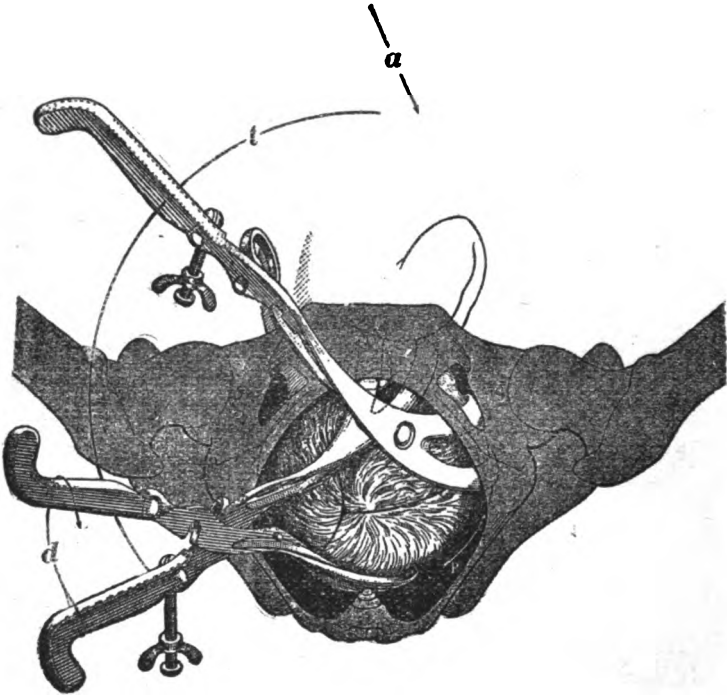


FIG. 48.

plied in the condition to be well placed, should be disturbed as little as possible.

It is the right, the pivoted handle, therefore, which will be brought about the other until it is in the proper position.

In summary, what is necessary is to uncross the handles, moving and separating them as little as possible, and keep-

ing them in contact ; it is not difficult to keep the hooks apart, but the height of the pivot is an obstacle difficult to overcome.

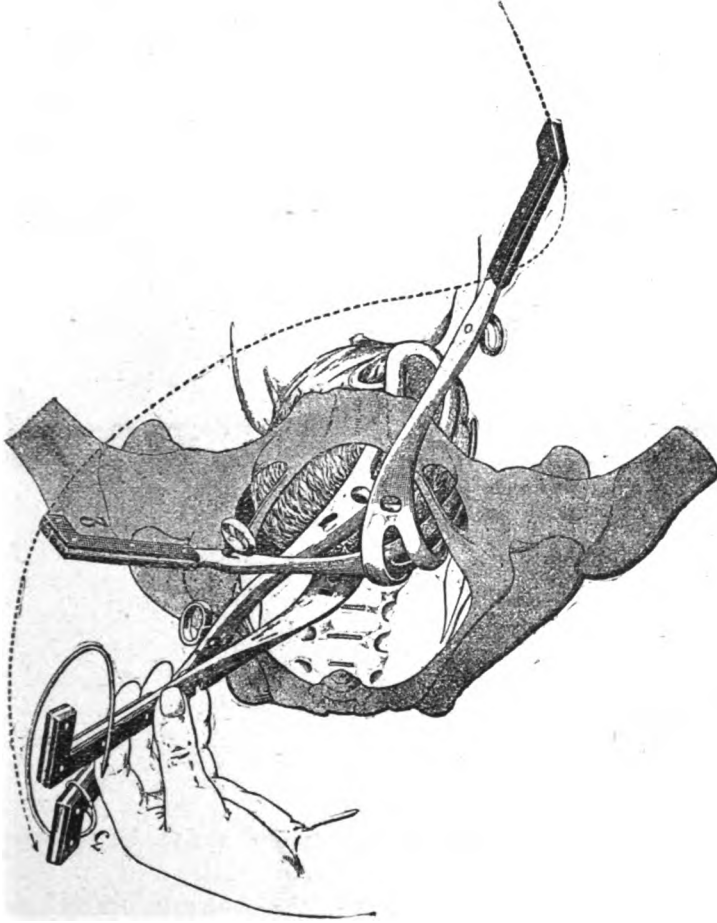


FIG. 49.

The one making the movement holds the hooks with the ends of the fingers : it is necessary to change the holding

once or twice, twice if the left handle is first taken in the left hand and the right in the right hand. Supposing that to be the case, we will describe the first change in manner of taking. The left hand having brought the left handle above and to the right of the right handle, takes hold of that also; the right hand being free, grasps the left handle, which it brings over the right handle, which is held nearly immovable in the left hand. By a new change, the right hand places the left handle in the left hand and takes the right handle to articulate the blades. The uncrossing is shown by the arrow, Figs. 48 and 49.

After the recrossing articulation is easy, if the position is right. If not, the only thing to be done is to commence the operation again, rather than apply any force in the endeavor to bring the articulating surfaces in apposition.

Knowing that, in the posterior positions, flexion is usually incomplete, the fourchette should be depressed backward and to the left, as much with the hands as with the forceps, for the purpose of seizing the head in its length. For this reason, the handles are not as much raised as in the corresponding position, occipital right anterior.

#### VERIFICATION.

The articulation made, it will be seen that, like the forehead, the handles will be directed forward and to the right; this direction will indicate, if the application of the forceps is correct, that rotation has not been made. The actual position of the head and the taking of the forceps may be ascertained by touching the head with the index finger beneath the forceps; the posterior fontanel should be felt backward to the left, the sagittal suture in the oblique diameter bordering forward to the right.

The position of the handles of the forceps being what it should be for such a position, shows that the application is correct.

## A CASE OF CHOREA OF PREGNANCY.

BY MARY A. COOKE, M. D.

**W**HILE chorea of pregnancy is not an extremely rare disease it certainly is not a very common one, and the case reported is furnished here as a contribution to the very meager literature of the subject.

Mrs. B. M., age twenty-six. Born in Ireland, been in the country about six years, housewife. Very little could be learned of previous history, but seems to have enjoyed fair health previously. One child fifteen months old. Thinks she is more than five months advanced in her second pregnancy.

Patient entered the Woman's Homeopathic Hospital, Philadelphia, July 6, 1895.

The statement of the case is as follows: First pregnancy normal and nothing unusual about delivery. The menses appeared once only on December 20, 1894. She nursed her babe till April previous to entering hospital. She felt life in June, but insisted the date of confinement would be the latter part of September.

The abdomen was but little distended and the muscles were very tense, there was hypersensitiveness of vagina and constant choreic movements. This made a bimanual examination very unsatisfactory, and it was about impossible to arrive at anything definite as to duration of pregnancy in that way. The choreic movements seemed to affect the whole body. She complained very much of pain in back and throat. She will only take food in liquid form on account of difficulty in deglutition. Could not talk intelligibly, though she understood all that was said, but was unable to articulate distinctly. At times she cried, screamed, etc., and was quite hysterical. She was very pale and much emaciated. Her husband said she had lost flesh rapidly. Choreic movements were present, though in a very much

modified form, even during sleep. Her temperature was normal, bowels regular, and her urine free from albumin.

She had been in this condition for about two weeks at date of coming to hospital, but she had shown evidences of the trouble for a much longer time.

About six months previously her husband had been thrown out of work, and not obtaining more they were obliged to give up their house and moved into two rooms. Patient had tried to take a place to do general housework during the spring, but was obliged to give it up after a few days' trial, saying she did not feel strong enough. During a portion of the time before her husband again obtained employment there is no doubt she did not have sufficient food, which, added to the anxiety on account of their financial state, was no doubt a causative factor in the disordered condition from which she was suffering.

For some months she had been looked upon as queer by the neighbors. Had been observed to jerk in her movements. She became very cross to the child, and sometimes was violently angry apparently without cause. Her disposition seemed entirely changed. She would often sit in moody silence and seemed unable to perform her simple household duties. About two weeks before her admission to the hospital she had been taken with what the neighbor described as a fit. She fell down, became unconscious, hands and feet jerked. She had to be carried to bed, and did not regain consciousness for some time and then seemed in a dazed condition. The next morning she got out of bed while her husband was still sleeping, and was found sitting undressed in a corner of the adjoining room. When asked why she was there, she did not seem at all conscious of her acts. From that time the choreic movements were very violent. She could hardly be kept in bed and could take very little nourishment, and became very much reduced in flesh and strength.

When she entered the hospital she frequently said she

was hungry, but could take only liquid food on account of the difficulty of deglutition. She asked frequently for cold water, which she drank eagerly. Was very excitable at times, and had fits of violent anger, when she would scream and make a great deal of noise. The movements were so violent at night that it became necessary to tie another bed to hers, to prevent her falling to the floor. Agaricus 3x was administered, and later ignatia 3x.

For several days she seemed to rather become worse, except that she could take more food, but was losing strength. It was decided to call a consultation of the gynecological and obstetrical staff of the hospital to decide whether or not it would be best to bring on an abortion. It was decided to wait a week or ten days, unless she exhibited alarming symptoms.

At this time complained much of her back, and pain in throat. At the suggestion of Dr. M. McFarlen strychnia 30th was administered. She had the spine douched daily by hot water followed by cool water. She was extremely nervous, almost violent, the night following consultation, which condition was most likely caused by excitement of seeing several physicians. The next day she had a visit from her husband, whom she seemed to have taken an idea was going to desert her, and after that she was more quiet. Not much difference for several days. She had an attack of epistaxis; blood of a bright red color. Had two or three attacks of vomiting, but on the whole her bodily condition seemed slightly improved; her mental condition seemed bordering on insanity. She had in addition to the douches to spine frequent baths, and spent part of every day in the pure air, and every attention was given to her general health.

In spite of all this she made very little progress, and on July 23 a second consultation was called, as some of us feared that she would become demented before pregnancy could terminate by the natural means. It was decided to

ask Dr. C. Raue to see the patient, which he did the following day. His prescription was puls. 30th, with a continuance of the douches to spine, etc. For two or three days she seemed rather worse, but by 29th was reported as sleeping better. Gradually improvement set in. August 3, the report was: face seemed brighter, twitching decidedly less. Still complained of pain in back and throat. August 14, complained of vertigo and severe frontal headache; this lasted about two days. On 24th, another attack of headache accompanied by nausea and vomiting. Both of these attacks were controlled by puls. August 28, the muscular twitching had disappeared, and patient's health was fair. The abdomen had by this time increased in size much more rapidly, and she complained of pain and soreness there at times, but she was wonderfully improved. September 15, not sleeping as well and complained of feeling very weak.

This condition lasted five or six days when she again became about as well as before. October 10, complained of feeling very weak, had hot and cold flashes over body, some pain in abdomen of a laborlike character. These symptoms continued four days, becoming more severe. The os was dilated nearly the size of a silver quarter, and as we thought labor was coming on she was sent to the maternity department. She had before been in the gynecological department, as it was thought best that she should be there during her long period of waiting. The symptoms of speedy labor disappeared soon after her transfer, and for some days she felt tolerably well.

From October 25 to November 7 she suffered much with occipital headache, nausea, and abdominal pains. Puls. did not give her relief as heretofore. On last mentioned day pains in epigastriks upon nausea, and she twice vomited dark blood. Dr. Raue was again consulted and prescribed lycopod. 30th, which soon gave relief. Continued feeling pretty well till November 28, when there was a slight dis-

charge of blood from vagina and labor pains set in. They seemed to lack force, and dilatation progressed very slowly. Puls. seemed indicated, but its administration was not attended with any marked benefit. After about twenty-four hours dilatation was nearly complete but pain seemed ineffacious and no progress was apparently made. As patient seemed to be losing strength it was decided to apply the forceps, though head was still in superior strait. Chloroform was administered, but patient did not take very well so the anæsthesia was not pushed. After some difficulty the instruments were applied and locked, and after about an hour's work she was delivered of a female child weighing about eight pounds. In spite of all precautions there was a slight laceration of the perineum. This was repaired immediately and united fairly well. Her recovery was normal and the course of it uninterrupted. One or two days there was a slight rise of temperature owing to a little irritation of the stitches.

Neither mother nor child showed any untoward symptoms as might have come from the long time the mother was out of health. She left the hospital in good condition the fourth week after delivery, and since that time I am sorry to say we have lost trace of her. She was told before leaving that if she were not well she must present herself immediately in the clinic, and as we have heard nothing from her the presumption is that her health has continued good.

The case was to me one of unusual interest, as I had never before seen a case of this kind occurring during pregnancy. Though it appeared well-nigh hopeless at times, we had an exemplification of the power of the well-selected remedy combined with close attention to hygiene.



## CAPILLARY BRONCHITIS.

BY S. J. QUIMBY, M. D.

TO the physician who faithfully follows the precepts of the immortal Hahnemann, careful attention to the symptoms, temperament, disposition, and individuality of a patient will ever serve as a reliable guide for the selection of remedial agents. True as is this assertion, yet these are only *guides*, and to fully grasp the necessities of a case we must often consider pathological conditions. This is demonstrated in some of those sharp, sudden attacks which bring to view, secondarily, marked cerebral and spinal symptoms, and is nowhere better illustrated than in the subject of this paper, capillary bronchitis or infantile pneumonia. Owing to anatomical conditions, acute inflammatory affections of the respiratory apparatus of early child life must ever remain of serious import. This is at once evident when we examine the structure of the air tubes and surroundings.

In adult life, the fully developed bronchia are hollow, cylindrical tubes, with walls of four distinct layers or coatings, designated as follows: The external or fibrous; the middle or muscular; the internal or elastic; the mucous.

The external layer is a dense meshwork of connective tissue in which are planted cartilaginous rings. The latter diminish in numbers as the tubes decrease in size, gradually lose their circular formation, and finally become extinct. The muscular layer is unstriped muscular fibers, highly developed between the cartilaginous rings, increase in comparative area as the rings disappear, and finally surround the bronchioles. The elastic and mucous layers extend to the termination of the tubes.

The bronchia divide and subdivide, until they form minute channels, which terminate in the air cells after ramifying amid a rich vascular mass of arteries, veins,

nerves, and lymphatics. They free themselves of accumulating secretions by the contraction of the muscular coat, together with the action of the diaphragm, and in the minute tubes by possible capillary influence.

During infantile life and early childhood, the muscles are so soft and deficient in contractile power, as to be unable to efficiently perform these offices whenever irritative or inflammatory processes cause the tubes to be suddenly filled with secretions. From this cause we have systemic poisoning from vitiated blood. At the same time there arises a congestive action in the vascular mass, which produces a more or less profound impression upon the brain and spinal system. When we consider how completely the bronchia are obstructed by this condition, and how sensitive the lung mass is to inflammatory influences, we cease to wonder at the fatality of infantile pneumonia. Owing to secondary nervous impressions it sometimes simulates cerebro-spinal fever in children who are teething. In this instance we find a hot somewhat dry skin, pulse inclined to be excited and of uneven volume, not very frequent, irritative cough, flushed face, sudden starting from sleep, general restlessness, and more or less delirium. About the only strongly characteristic symptom wanting to complete the picture is rigidity of the spine and general convulsions. Without auscultation of the lungs the true cause of the cough may, at this stage, escape observation and be classed as a reflex irritation from teething. We see here the necessity for an early recognition of the pathological condition. In the one case, external applications to the thorax will tend to modify the inflammatory action and assist remedies, while the other will demand applications to the spine. It is not the purpose of this paper to discuss the nature, history, and well-known characteristics of capillary bronchitis, but rather to call attention to a lesson in pathology, which is this. When called to a child suffering from cough and sudden rise of temperature, carefully examine the lungs for signs

of acute inflammation of the minute bronchia. The same caution will apply to the aged, who are in their second childhood.

As to treatment we will say, look well to the external conditions of the patient. Above all things, first, protect the lungs from atmospheric influences, and maintain the stimulating and relaxing action of heat. For this purpose, envelop the thorax in an oil silk vest lined with cotton or wool, and use in connection therewith rubber bottles partially filled with hot water and changed as often as cool. When moist heat is required, a flaxseed meal jacket, changed every six hours, will meet the indication used in connection with the bottles. Maintain in the room an abundant supply of fresh, dry air at a temperature of 65° or 70°, carefully avoiding all drafts. When the bodily temperature is high, sponge the face and limbs in a bath of vinegar and water, or soda and water, the temperature being one or two degrees below that of the body. In case of severe thirst, a moderate supply of cool drinks will prove grateful and beneficial. Support the strength with such liquid nourishment as the digestive organs are able to assimilate.

If the attack is brought on by a sudden chill from exposure to cold dry air, and the child is restless with a dry hot skin, short dry cough, and full, hard, and somewhat rapid pulse, then give aconite.

If there is a short, irritative cough, hot, burning skin, red, flushed face and sudden starting in sleep, belladonna will meet the indication.

After the first day if the cough is somewhat loose, and the child becomes delirious, talks of the events of the day, desires to lie undisturbed, and has thirst for large drinks of water, bryonia is required.

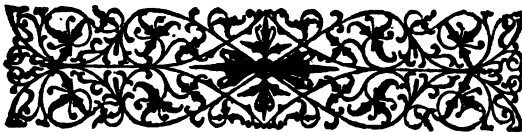
When the attack is of a less acute onset, and the child in nursing suddenly lets go of the nipple and cries and at the same time desires to be carried about and held upright, ant.

tart. may abort the disease. If in the advanced stage, the child wheezes in breathing, the chest seems full of phlegm, the cough, though loose, becomes less and less frequent, the head hot and bathed in sweat, the pulse weak, then ant. tart., if promptly given, will often work wonders.

Ipecacuanha will be of especial service for fat chubby children of lax fiber. They are sensitive to warm, moist atmosphere. There is difficulty of breathing. Chest seems full of mucus and the phlegm is vomited.

If the inflammation extends to the air cells then phosphorus may be indicated as shown by its symptoms. This is a summary of the characteristics of the more prominent remedies thus far called for in this disease.

When we study well each case, so as to apply remedies as taught by the great master of homeopathy, we shall rob the grave of many a victim.



## ÆTIOLOGY OF UTERINE DISORDERS IN GIRLS.

BY J. E. BUCHANAN, M. D.

WHEN I began the practice of medicine I soon found that the large majority of my patients were women, and it did not take me long to discover that the greater number of these women were suffering from diseases contracted or acquired prior to assuming the marriage state, and because of the similarity of their histories, I was led to look closely and try, if possible, to discover the primal cause for this almost universal state of invalidism, and to offer a remedy therefor. We who have had any experience in treating this class of patients, know that irregular and painful menstruation is the rule rather than the exception.

Instead of the menstrual period being, as it normally should, a slight departure from the ordinary healthy condition, it becomes a period of intense and frequently prolonged suffering. In such cases this epoch is anticipated with horror. On questioning these girls, especially if they be very young, we get little or no light on the case; we gain little by closely questioning the mothers; they will tell us that the suffering has existed since the establishing of the menstrual period, or begun soon after, and has grown gradually worse until it has become almost unbearable. From observation and close study of these cases, I am convinced that the causes are two-fold, *i. e.*, dress and education.

The dream of the fond mother of to-day is to have her daughter "shine" in society. Therefore, at a very tender age, rarely over fifteen, and more often from twelve to thirteen, that curse of physical womanhood, the corset, is put on, just at the time when the girl is undergoing rapid developmental changes, and the organs of generation and reproduction are taking on their individual character-

istics, and the general contour of the child begins to round out into the fully developed woman, art lends a hand to accommodating Nature to help beautify the poor girl.

Dr. T. G. Thomas says: "The dress adopted by the woman of our times may be very graceful and becoming; it may possess the great advantage of developing the beauties of the figure and concealing its defects; but it certainly is conducive to the development of uterine diseases, and proves not merely a predisposing, but an exciting cause of them."

Dr. Holton says, when speaking of the corset: "The youthful wearer of these evil contrivances, unaware of the delicate organs compressed and restricted; unaware of the divine uses to which these same organs may be put, draws them tight and tighter about her yielding, young form, and imagines the instrument of her undoing to be an actual source of strength. I have had young things of sixteen tell me they cannot sit up without their corsets, as without them they had such a 'gone feeling'; moreover they thought it preserved the figure."

We know full well that when Art and Nature join hands in the shaping of the human body, poor old Nature is soon kicked out at the back door, so to speak, and Art takes full control. How often we have seen her delicate victims laid by in the sick-bed, then the true old friend, Nature, that has been so shamefully treated, comes to the rescue, assisted by the family physician, and as soon as she is restored, that false friend, Art, again takes charge and away she goes for another whirl.

The result in the so-called fully developed girl of to-day is that she is a perfect fashion plate, with partially developed misplaced and misshaped vital organs. The thoracic cavity in which dwell these organs is vastly lessened, being imprisoned as it is by these tightly laced steel bands. Is it any wonder that these persons suffer from palpitation and shortness of breath? We know that a lesion in any organ of the body

will soon produce a corresponding condition in other and more distal parts of the body. Therefore, when the respiration is interfered with, let the cause be what it may, there is a corresponding diminution of the interchange of pure air with the accumulating poisons of the body, necessarily producing disease. And when the heart is restricted in its action it cannot possibly force the blood, though but partially purified, to other and dependent parts, and we can readily see what an appalling state of affairs will sooner or later exist. But this is not all, the abdominal viscera are pressed down on the pelvic organs, thereby retarding their development, and we have the story complete. Soon follows the inevitable effect; added to the mal-menstrual epoch we find deranged stomachs and bowels, headaches, backaches, cannot stand the minimum exercise, followed by nervous prostration, hysteria, and the gynecologist.

The second cause for this alarming state of affairs, and one of necessity interblended with the above, is the improper education of the girl of to-day. They are put in school at the tender age of seven and the cramming process begins. As they progress their studies become harder, and more exacting, until at that most critical period in the girl's life, *i. e.*, from twelve to eighteen, they are pushed for all there is in them, laced frequently to the last hole. The inexorable law, "that we reap what we sow," proves too true in these cases. But poor outraged Nature stands aloof, keeping her eyes fixed on these misguided beings, ready to lend a hand whenever permitted. As to the remedy for this condition. I do not think we will find it in the doctor's medicine case. True, relief, by the proper application of drugs, can be and is given every day. But we seek a cure. Neither do I think we will find it in the gynecologist's armamentarium, nor the surgeon's knife. But the remedy, I think, is fourfold, *i. e.*, proper dress, proper education, proper physical exercise, and hygiene. I believe in giving the girl the same privilege in the matter

of dress and out door exercise as is accorded the boy. In this day and age when women are saying so much regarding "woman's rights," I sometimes wonder if these lessons are applied in their own homes. The thoracic, abdominal, and pelvic organs should be perfectly free, at least, while in process of development. I am heartily in accord with the so-called new woman of to-day. I also commend to mothers the bloomers, minus lacing, and the bicycle for their daughters. But I insist on the corset being cast into the "bottomless pit," and instead, if they must have a substitute, I would recommend the Jenness Miller waist. I am a firm believer in giving the girl the very best education possible, but education must be made subservient to the laws of health. She should be taught to know herself, her functions and possibilities. A healthy, vigorous body containing a healthy cultured mind and a sweet, amiable disposition is God's ideal creation for woman.

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## CHRONIC SURGICAL DISEASES.

BY JOSEPH H. DRAKE, M. D.

**I**N order to do our full duty in the battle for life and sustenance it is necessary to have good health. If we are sick we are a burden to ourselves and our friends, and we cannot enjoy life, nor, though many times expected to do so, are we able to play the part in life required of us. There is no person realizes these facts more than the chronic sufferer, and the causes are not enumerable—they are beyond ordinary comprehension, therefore I will only mention a few of the most comprehensive surgical conditions causing chronic diseases, or from which reflex conditions arise and very soon become chronic, and, if not incurable, exceedingly tedious to cure.

First, we have to contend with tumors of the brain—many varieties causing more or less disturbance of the entire nervous system. Yes, and oftentimes of the entire



body, to the extent of paralysis. These conditions, or symptoms, that follow the development of the tumor are reflex. In tumors of the stomach, liver, pancreas, spleen, bowels, ovaries, womb, and testicles, all have their train of sympathetic troubles. All persons having the same class of tumors do not have the same reflexes to follow the appearance of the tumors, but in a sense they are all chronic, and we may term them chronic organic surgical diseases, which will nearly always abate soon following the removal of the tumors if they are operative, and these reflex or sympathetic diseases which are the result, and not primary, cannot be cured until after the cause, which of course is the tumor, is removed by surgical interference.

Another class of surgical conditions we might call them, are those peculiar to women, oftentimes following child-birth, such as peritoneal and cervical lacerations and overstraining of the rectum, causing redundancy of the lower bowels, piles or hemorrhoids, and fissures; any one or all of them may, and we might say always have, their train of reflexes, which can well be called chronic surgical diseases because it is the same with their conditions as with the tumors—they cannot be cured until the cause is removed by surgical interference.

And we may mention the third class of sufferers that come under this head; viz., the young ladies who suffer during their menstrual periods, from stenosis of the uterus and membranous dysmenorrhea. These conditions always have their weak points, apparently foreign to the more noticeable pain which occurs during the menses, and cannot be removed except by surgical interference. There is still another condition that is very marked in many of the patients who suffer from stenosis or dysmenorrhea; it can be called multiple neuritis, simultaneous inflammation or irritation of many nerves, from multiple excrescence, papillar growths of the vagina, whose invasion often extends to the clitoris, meatus urinarius, and perforate or unperforate hymen. These difficulties are not usually noticed, and the

patient grows more and more nervous until they often-times assume, or cause, distressing spasmodic nervous conditions, or insanity, which cannot be cured except by first mowing them off with the scissors time after time before you can overcome them, at the same time prescribing the very best indicated remedies in order to make the treatment successful.

As results of neglected causes, we find patients who have suffered for months, or perhaps years—not from the primary trouble, but the reflexes. For instance, we need not take your valuable time in describing the reflexes of the major trouble, such as ovarian and other tumors; we may take laceration of the cervix and perineum. I have had a great many ladies come to me for treatment who had suffered for many months, or perhaps years, with nervousness, headache, dyspepsia, heart trouble, constipation, hypertrophy of the liver, pancreas, or spleen, or perhaps atrophy of the same organs, neuralgia of some nerve center, and great emaciation and weakness or asthma; and during our quiz of the patient we find that she has not been well since Jim was born, eight, ten, or perhaps twenty-five years ago, and she is greatly surprised when our diagnosis is made and we say to her that the whole cause is the result of the laceration which occurred so many years ago, and is more surprised when she rapidly recovers from all her ailments after the operation has been successfully made and she is rapidly regaining her health, and finally in an unspeakably short time she is strong and well and able to look after the family affairs; a thing that perhaps some of her children almost grown to manhood or womanhood had never known their mother to do, and the mother is surprised that physicians by whom she had been treated for these long years had never mentioned the fact that this injury had anything to do with her suffering or even looked for the cause.

The moral in this short paper is in the fact that all chronic diseases are the result of careless diagnosis or no diagnosis at all.

## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

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**REPERTORY OF TONGUE SYMPTOMS.** Arranged by M. E. DOUGLASS, M. D. Philadelphia: Boericke & Tafel; 1896. Cloth, \$1.00.

We are always glad to welcome such a book as this which tends to lighten the labor of the physician in looking up the remedy in a case. It is complete, concise, and easily handled, and as far as we have occasion to refer to it accurate. Part I. gives the repertory proper of tongue symptoms; Part II., repertory of mouth and tongue symptoms in typhoid conditions; Part III., remedies, giving the prominent tongue symptoms under each remedy.

**MANUAL OF PATHOLOGY.** By GEORGE F. WASHBURN, M. D., Professor of Pathology in the Chicago Homeopathic Medical College. Medical Century Co., Chicago, 1896; pp. 122, Ill.

This unpretentious volume, intended for students of pathology, is one of the series of student's manuals issued by the Century Co. It is clearly written and arranged to make it valuable for hasty reference, each chapter closing with a quiz compend.

**A MONOGRAPH OF DISEASES OF THE NOSE AND THROAT.** By GEORGE H. QUAY, M. D., Professor of Rhinology and Laryngology in the Cleveland Medical College. Philadelphia: Boericke & Tafel; 1897. Cloth, \$1.25.

This book, which is the outcome of the author's experience in the general practice of medicine, supplemented by several years of special work in diseases of the nose and throat, is intended for the use of the student as well as the physician.

For the work in this line which the general practitioner has to do he has neither the time nor the inclination to go exhaustively into the subject, so that a book which condenses for him the information he needs will prove valuable and useful. The author emphasizes the necessity of treating the diseases in their

totality ; that while many conditions require operative treatment, internal medication should not be neglected ; in other words, treatment must be both general and local. Decided and just prominence is given to the homeopathic treatment.

The style of the author is clear, though very condensed, and the book will doubtless meet with a large sale.

**TRANSACTIONS OF THE SOUTHERN HOMEOPATHIC MEDICAL ASSOCIATION ; Twelfth Session.** Baltimore : Southern Journal of Homeopathy ; 1896.

We are indebted to Dr. C. R. Mayer of New Orleans for the bound volume of the transactions of the Southern Homeopathic Medical Association.

It is a volume which does credit to our brethren of the South, well printed and bound, and containing a number of excellent papers.

**FIVE YEARS' WORK IN SURGERY.** By HORACE PACKARD, M. D., Professor of Surgery, Boston University School of Medicine. Boston : Press of Samuel Usher, 1896.

This little book gives the summary of the author's work in surgery for the past five years, with comments and deductions based upon a series of 1387 operations. The author offers it to his colleagues to lay before them for criticism and trial various new methods, and modifications of old ones, which it is hoped may prove of some value in the future. It is well illustrated and contains much of interest.

**A COMPEND OF THE PRINCIPLES OF HOMEOPATHY,—as taught by Hahnemann, and verified by a century of clinical application.** By WILLIAM BOERICKE, M. D., Professor of Materia Medica and Therapeutics at the Hahnemann Hospital College of San Francisco ; associate author of the "Twelve Tissue Remedies of Schuessler," "Stepping Stone to Homeopathy," member of American Institute of Homeopathy, etc., etc. Price \$1.50. San Francisco : Boericke & Runyon, 1896.

Upon Hahnemann's Organon homeopathy has been built, slowly and laboriously, course by course, until it has in those later days attained such proportions that the corner stone upon which it rests is sometimes lost sight of and the principles of

homeopathy forgotten. A book like this one therefore is timely and valuable as an aid to the student in acquiring a correct knowledge of the principles of homeopathy, as the author well says :

“Hahnemann's *Organon* is the great text-book of the homeopathic school. It contains philosophical conceptions and practical directions for the establishment of a true science of therapeutics, and all genuine progress toward this goal is in the direction pointed out in that work. To fix its principles clearly in the mind of the student, to faithfully apply them in practice, is the special duty and high privilege of homeopathy. The more this is done, the more will this masterly book become a veritable mountain of therapeutic light to the practitioner.”

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## Materia Medica.

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***Kreasote in Leucorrhœa.***—Dr. Kent.—Produces an acrid leucorrhœa, leaving yellow spots on the linen. It has the peculiar smell of green corn, and stiffens the linen as if it had been starched. This person is always chilly, has a weak memory, and her head buzzes and hums so that she is hard of hearing. This is a great remedy for the leucorrhœa of pregnancy.

***Helonias in Threatened Abortion.***—Dr. Danforth.—Threatened abortion from atonic conditions ; especially in habitual abortion ; slightest over-exertion or irritating emotion tends to cause loss of fetus. Had been flowing for several days ; severe bearing down pains preventing sleep, great pain in small of back ; walking about excites pains. Useful for many of the consequences of miscarriage.

***Lachesis in Measles.***—Dr. McElwee, S. J. of Hom.—Alarming prostration. The rash is slow in appearing, or appears very imperfectly, reminding one of bryonia, but is too blue for that, and the patient too restless and sensitive about the neck for bryonia to be thought of. If there is any fever, the patients are not much delirious with it in this condition, but sleep more and

are difficult to awaken, being all the worse, apparently, for having slept.

***Caulophyllum in Uterine Diseases.***—Caulophyllum is a general systemic sedative and antispasmodic in its action. It exerts a decidedly alterative influence on the uterus, whence its value in subinvolution and endometritis. It also exerts a similar influence upon the ovaries, whence the benefits resulting from it in amenorrhœa and menorrhœa. Its antispasmodic action is evident in its influence over hysteria. In threatened abortion and allied conditions it is of value.

***Rhus Tox. in Coccygodynia.***—Dr. C. S. Elliott.—Med. Arena.—Stiffness and lameness in the sacrum, worse on resting after exercise; pain in the small of the back, worse when sitting still or when lying; better from lying on something hard or from exercise; drawing, jerking stitches as with a needle in the coccyx; heaviness of the lower extremities; lower extremities feel bruised, they are so weary. Rhus is especially useful where there is a rheumatic tendency, and especially where the affection is brought on from exposure to cold and dampness or from sitting on the damp ground.

***Viburnum Opulus, the Uterine Action of.***—Dr. Cowperthwaite (Med. Era) says that the provings of viburnum prove conclusively its action upon the uterus. All women provers reported symptoms simulating uterine congestion, and had disturbed and painful menstruation. Clinically the drug has proved invaluable in congestive and neuralgic dysmenorrhœa, and has often given relief in the membranous and obstructive varieties. Viburnum rarely fails to give prompt results if its symptoms are present, but unfortunately its action seems to be more palliative than curative, as the conditions usually return after three months. Dr. Cowperthwaite is inclined to think that if the higher potencies were used this would not be the case.

***Ova Testa in Leucorrhœa.***—Dr. Edson (Hom. News) notes seventy consecutive cases treated with ova testa, without a single failure. He considers the symptoms, "feeling as if the back were broken in two and tied with a string," as specially characteristic. He also mentions a case of profuse leucorrhœa and metror-

rhagia, the patient being almost bloodless, in which a dose once a day restored her to rosy health in two months. She noticed that if she took it too frequently it produced a tired feeling and chills, and the disjointed sensation in the back. Dr. Edson has also found it to have a wonderful effect in controlling the suffering of cancer. The ova testis is prepared by being browned in vacuo and then triturated. He has always used the 3d trituration.

***Petroselinum in Urinary Incontinence.***—Dr. B. G. Carleton (N. A. Jour. of Hom.) records the case of a female, æt. two years six months, in whom there was urinary incontinence of six months' duration. No abnormal condition noticed in first two years. Treatment by Old and New School physicians, with usual hygiene for the six months, availed nothing, and the case gradually grew worse. There were no deformities of the parts. Chemical and microscopical examination of the urine gave evidence of no abnormal condition. Pathogenetic symptom: Frequent desire to urinate. Clinical symptoms: Sudden irresistible desire to urinate. The child awakens at night, and if not taken up at once, the urine is passed involuntarily. During the day the desire is frequent and sudden, the discharge of urine occurring before the child could call the mother or nurse. *Petroselinum* 3x, the indicated remedy, cured in one week.

***Melilotus Alba in Eclampsia.***—Dr. G. W. Bowen.—I will not take albuminuric cases unless they will let me treat them for a month. After four weeks' time, if they are not a great deal better, I want a month more. Belladonna will relax the circular muscular fibers of the body; it will relax the ureters, allowing the water to pass. Arsenicum prevents contamination in any shape or form. I have counted as closely as possible on short notice, and remember having seen eleven cases of eclampsia in four and forty years. Seven of these were my own cases, the balance I saw in consultation. In the last six cases I have relieved the spasms inside of one minute. Spasms come from pressure on the brain or nerves. I am pleased to state what will stop epileptiform, infantile, or eclamptic spasms in one minute; it is *melilotus alba*. Spasms result from pressure or interference with circulation. I put it in the mouth, even in case of epileptics lying on the street.

I have given nothing else for fifteen years, for any kind of spasms. I introduced this remedy to the medical profession. It will stop bleeding from the nose in almost every case. I use it in the first centesimal potency.

***Cimicifuga in Backache.***—Dr. Elliott, Med. Arena.—Severe pain in the back, down the thighs and through the hips, with heavy pressing down; weight and pain in the lumbar and sacral region, sometimes extending all around the body; bearing down in the uterine region and small of the back; sensation like electric shocks here and there; sharp lancinating pains in various parts associated with ovarian and uterine irritation; rheumatic pain in the muscles of the neck and back; feeling of stiffness and contraction; limbs feel heavy and torpid, dull pains in the occiput, with shooting pains down the back of the neck; top of the head feels as if it would fly off; worse going up stairs; declares that she will go crazy.

Actea is one of the chief remedies in this affection. It not only has a special affinity for the tendinous tissues involved in this affection, but also, as thuja, has the occipital headache like that in coccygeal reflex headache.

***Calcium Carbide in the Treatment of Cancer of the Uterus.***—M. Guinard states (Gazette Medicale de Paris) that for the last three months M. Peyrot had employed this substance in treating cancer of the uterus; the mode of treatment being as follows: A piece of the calcium is placed directly in the vault of the vagina, where it very soon becomes decomposed into calcium oxide and acetylene by contact with the moisture. At the end of several days the oxide is removed by means of irrigation with corrosive sublimate. This treatment could be repeated several times. The results are very appreciable, for the diseased parts assume a grayish tint and become smooth, and the hemorrhages, the fetid discharge, and the pain are suppressed by this procedure. Diarrhea could be avoided by the employment of small pieces of this substance. The mode of action of calcium carbide is rather complex. The nascent quicklime acted, without doubt, in concert with the acetylene, which passed into the urine, where it had been found. Perhaps, by contact with the cancerous elements, it formed a special coagulation of the blood, analogous to



that which was observed in persons who had been poisoned by gas.

***Belladonna in Spasms of Vagina.***—Brit. Hom. Soc.—A woman, aged forty-six, married for twenty-two years, no children, complained of a burning feeling in abdomen and forcing-out of the rectum, which her previous physicians, without troubling themselves to make an examination, attributed to hemorrhoids. Though there was some costiveness, defecation was not particularly painful; the bowel pain was worse by night than by day. No menses for two months, though previously regular, rather copious, with a transient cutting pain immediately before the flow. Examination revealed nothing besides a retroversion of the uterus, but caused a spasm of the vagina, which became energetically contracted, showing that there was here abdominal irritability. The administration of belladonna 30th twice a day for ten days diminished the pain considerably. The same medicine was continued once a day for twenty days longer, and pain no longer occurred without exciting cause, examination did not again bring on the spasm. The costiveness had nearly disappeared; it was obviously owing more to extreme irritability of the sphincter than to inaction of the bowel. The menses again appeared.

***Kreosote in Metrorrhagia.***—Dr. Sybel, Allg. Hom. Zeitg.—A woman in the climacteric period was very much weakened by a considerable metrorrhagia; after the bleeding had diminished under allopathic treatment, and recovery seemed to be at a standstill she consulted homeopathy.

An anæmic condition prevailed in consequence of the large loss of blood which was still sustained by a continued moderate flow. China, followed by some other remedies, alleviated her condition, so that she could again, in a measure, attend to her household duties; but the hemorrhage had not ceased entirely. Four weeks had passed after the first flooding, when it began to again increase in severity; this was accompanied by chilliness, loss of appetite, diarrhetic stools, and a sensation as if everything were about to fall out of the abdomen. The blood voided had a very disagreeable smell. On account of the general anæmic condition bell. seemed contra-indicated, and I thought of platina and

pulsatilla. However, platina 3d did nothing, and pulsatilla, while it alleviated some, failed to act satisfactorily. I then gave, on account of the very bad smell, kreosote 4th; this soon effected a complete cessation of the flow of blood, and soon brought about such favorable change in the whole condition that the patient felt better than for many months.

In another case, also a woman in the climacterics, kreosote 4th also proved to be efficacious. In this case also the bad smell of the blood was a marked symptom.

***Nux Vom. and Sepia in Two Cases of Dysmenorrhea.***—Dr. Neatby.—1. Miss C., æt. nineteen, had suffered from pain at the period for three years. Menstruation, occasionally premature, was somewhat profuse and lasted one week, the hemorrhage was bright and in the early part clotted. The pain was in the hypogastrium only, and began one day before the flow, lasting forty-eight hours in all. While present varies in intensity. While the pain is present there are waves of nausea, but no vomiting.

Apart from the period patient had sharp dyspeptic pains one or two hours after food, the tongue was indented, she had sour taste after food, and in the morning the tongue was coated at the back. She was of an irritable disposition, dark and slightly sallow complexion, and her irritability was worse at the monthly time. She suffered from leucorrhœa, causing irritation, worse when warm.

She had headaches on the vertex and left side of head, worse in the morning and better in the open air. For medicine she received nux vomica 30th, three drops night and morning.

After several painless periods, she returned for præcordial pain, worse on going up stairs, and for dyspnœa. There was no cardiac disturbance. The abdomen was somewhat tender to the touch. There had been one painful period. Patient again received nux vomica, which was followed by sulphur, on account of increase of leucorrhœa. Both that and the pain disappeared.

2. Mrs. D., æt. forty, of dark complexion and spare build. Menstruation was moderate and regular; the pain was severe, sacral aching beginning one day before the flow and lasting two days in all. She had had four children, the last four and a half years previously. There was "bearing down" pain (much worse at the period), leucorrhœa worse from fatigue, but no protrusion;

no frequency of micturition. On vaginal examination, a lacerated perineum was found, the uterus easily prolapsed on straining, and was retroflexed. In addition to these local symptoms, patient complained of shortness of breath, pain in left chest and dry cough, worse in the cold air and after washing. For three months she took sepia 30th and 200th and the pain at the period disappeared. The bearing-down continued, however, and was only removed by repairing the perineum, after which she could walk, stand, and do her work easily.

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## Obstetrics.

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**Antiseptics and Hot Water.**—Dr. G. W. Bowen.—I was engaged on the 6th of the month for a confinement about the 10th; I was called on the 18th, at 9 P. M., about nine miles from the city. Labor was concluded in one hour, but there had been no motion felt for several days. The baby was blue. I put it in water as hot as I could bear on my hand and in less than three minutes it began to cry. It is all right now. I removed the after-birth, which was black and friable; there was no odor, as the air had not reached it. I scraped out all I could with my hand and bandaged her. She was a little chilly and had some fever and sweat. I used no antiseptics to prevent infection. I gave her aconite and bryonia one, then two, and then three hours apart, and she is all right. I never use a cathartic. I have never lost a patient out of over fifteen hundred labor cases and never use anything but simple cleansing. I have saved the lives of nine babies—one of which was dead, supposedly, for two hours before I reached the house—by putting them in hot water. I saved one baby which had lain under water for half an hour, by the same method. One woman was laid out for the grave when I begged permission to put her in hot water. They finally consented, and in less than five minutes after she was put into the water she came to and is living yet. She had been lying in her coffin for a couple of days. Hot water starts up the capillary circulation.

***Albuminuria and Eclampsia.***—Dr. Sheldon Leavitt.—The phenomena observed in these cases come from auto-infection. The kidneys are unable to eliminate from the system all of the broken-down material, with the result that this condition is slowly but surely set up. Not always in cases of marked albuminuria does it go on to eclampsia. I remember one case, at the seventh month, where the urine was so loaded with albumin that it was almost solid, on boiling. She came to me complaining of ill feeling, but not recognizing her condition ; at the same time she was in a condition of anasarca—the tissues were loaded from the crown of her head to the soles of her feet. I watched the case attentively during the succeeding few weeks, but did not terminate the pregnancy. Arsenicum seemed indicated and was given. I placed her upon an exclusive milk diet. Gradually the albumin diminished in quantity, though at the time of confinement, which occurred some seven weeks later—a little in advance of full term—the urine was still loaded with it. The anasarca, however, had considerably diminished. She passed through labor, which was a rapid and easy one, without alarming symptoms. After confinement she seemed relieved in some respects, although for some days the urine continued loaded with albumin. This condition continued for about two weeks, and I was beginning to grow alarmed about the outcome of the case. I was finally led to give her sulphur and, after a few doses of the 30x, the kidneys became very active, the woman passed large quantities of urine, the tissues unloaded themselves, and in a comparatively short time the urine was entirely free from albumin. I have learned to attach great importance to the diet in these cases and place them on an exclusive milk diet. If I had to make a choice between this diet and the remedies, I believe I should choose the diet. As to eclampsia itself, I have had some interesting experience ; I have had about a dozen cases, one-half of them in consultation. In four or five of these, believing that the woman would stand a far better chance of recovery if the labor was terminated, I have instituted measures for delivery. In three which I can distinctly recall, I found an obstacle in the shape of a firm and unyielding os uteri. In one case it was found absolutely impossible to dilate sufficiently to admit of the insertion of

obstetric forceps. In these three cases, as delivery was immediately necessary, I incised the cervix on either side and delivered the fetus. The laceration was then repaired and good union resulted in every case. In one of these cases, however, examined quite a while afterward, I found the cervix notched on either side, but not to the extent very frequently seen after a normal labor.

***Inducing Labor in Albuminuria.***—Dr. H. P. Skiles.—I would like to ask how soon or how early in these cases are we justified in producing labor. I remember a case I had last winter, one which I had carefully watched since the fifth month, knowing that she had lost her child in the previous confinement and was very anxious for this one. Along in the middle of the sixth month she began to manifest symptoms of albuminuria. I gave her remedies, but at the seventh month it was still more pronounced. Motion was perceptible and she felt all right. Near the eighth month she complained of flashes of light. At the completion of the eighth month she was taken with sharp pains in the head, followed by convulsions. She had three convulsions; not being at home, my partner was called and gave chloroform. When I arrived I found her in a comatose condition. I introduced a bougie and induced labor; I could not hear the fetal heart-sound, so hurried things. During the next twenty-four hours she did not pass over one ounce of urine, although I gave her apocynum in material doses. I then tried apis, which gave a good result and the urine flowed freely. Apis had to be given for eight or ten days or the urine would almost cease. It was almost three months before she ceased having the flashes of light. How soon are we to induce labor and expect to have a living child? What are the indications for producing labor in these cases where, at the sixth or seventh month, there is much albumin in the urine? This question has excited a great deal of attention in our neighborhood from the fact that, within the last eighteen months, two women have died from injections of morphine on the eve of labor. The injections were given by different men, careful physicians.

***When to Induce Labor.***—Dr. Sheldon Leavitt.—We must be governed by the circumstances of each case. In all cases the practitioner should call counsel and if, in their judgment, it is the

proper thing to induce labor, no doubt the profession would uphold them, no matter what the stage of pregnancy. Where the parents are very desirous of having the child and are willing to assume some risk, or where they shrink from carrying out the suggestions of the physician, we are justified in allowing them to go on for a little time. As to treatment : I have learned during the past few years to place much reliance upon chloral hydrate. Belladonna is generally of service and gelsemium frequently so. While I have not failed to give the indicated remedy, I have sometimes done more ; thereby obtaining results not otherwise obtainable. I say I use chloral hydrate, and in these peculiarly grave cases, I use it freely by rectal injection. If the woman is having eclampsia and the seizures return again and again, and she is beginning to run off into a comatose condition between attacks, there is no time to be lost—those recurrent attacks must be broken up. Under these circumstances, I have before now dissolved seventy grains of chloral hydrate in warm milk, to which I added one egg, making sure that the chloral is thoroughly dissolved. This I give at one injection, and in one case I repeated it in two hours and brought the convulsions under control and saved the life of the woman. I have used this now in five cases, with a loss of only one. They were all very severe cases.

*The Treatment of Albuminuria.*—Dr. H. W. Champlin.—I am glad to say that I have never been face to face with puerperal convulsions ; I should not feel justified in allowing a case to go to full term with albumin, casts, and general anasarca. I was called to see a case last winter where the urine was almost entirely suppressed, tissues engorged, but no disturbance of vision. Labor was expected when I called, but held off a day or two, during which I had great anxiety. I gave her mercurius cor., and she was confined without bad symptoms. It was a case of twins, eight and nine pounds. The kidneys started up and eliminated gallons of fluid. I have always felt that in a case of this kind I should rely upon veratrum, fifteen or twenty-drop doses hypodermatically, and, if that failed, I should try venesection. I have had some recent experience in venesection in case of one of our citizens who was suffering with convulsions. There was no albumin in the urine in this case I spoke of. This man had two

attacks ; I was called both times. We found no apparent cause. In the second attack, after having convulsions for twenty-four hours, not even controlled by chloroform, we did venesection, since which time he has had no convulsions. He was quiet immediately after it, and has remained so ever since. It should be borne in mind as a last resort.

**Remedies for Albuminuria.**—Dr. L. K. Maxwell.—My experience with eclampsia is not very extensive, not having had any cases in my own practice. All my cases—three—have been in consultation. Have had quite a number of cases of albuminuria in my practice, some of them quite serious ; one case showing about five-sixths of albumin with œdema quite extensive. My custom, in these conditions of great œdema, with inactive kidneys, is to give a hydrogogue cathartic to get rid of as much of the fluid as possible ; prescribing, at the same time, the homeopathic remedy, which, after the relief afforded by the cathartic, acts much more promptly. The remedies most serviceable to me have been apis, arsenicum, and phosphorus. I have made it a rule to examine the urine of pregnant women at least once a week. Sometimes we anticipate much trouble and have none, and, in cases where we least expect it, we may have the eclamptic seizures.

**Hetero-Infection.**—Dr. L. C. McElwee.—As to hetero-infection : This touches the point of difference between hospital and private practice. I want to say that I have never lost a patient of my own from hetero-infection, although I have seen some fatal cases belonging to other practitioners. In labor cases I clean the hands as thoroughly as for a laparotomy and always put on an apron ; when not making an examination I keep my hands covered with a towel.

**Symphiseotomy :** I have been harshly criticised for advising this procedure, but have had no trouble with the healing of wounds. Some say, incise the perineum instead. I had a case in point last December, so I tried that. I incised as deep as the sphincter muscle and the head passed safely, then the shoulder came along and tore through the sphincter and for two inches up into the rectum. I made immediate reparation and the wound healed nicely, but since that I have made the incisions

laterally. When I have a case of obstetrics which starts, then stops and makes no headway for an hour, I use anæsthesia and deliver. I put them clear down, as for any other operation.

**Perineum inspection :** It is not always safe to make merely an ocular examination ; a digital examination should be made in each case. I delivered a woman a few weeks ago of a child which weighed  $13\frac{1}{2}$  pounds naked ; the head was ossified, and I had an awful time. There was no external laceration, but a chasm from the posterior lip of the uterus, down on either side. It healed very nicely.

**Curetting after abortion :** It has been my custom to tell my patients that I should not wait upon them unless they allowed me to curette. I will not take the risk of allowing a woman to become septic if I can help it, but give a little anæsthetic and curette. I have had three cases of cracked nipples which persisted in spite of remedies, but immediately after the repair of a lacerated cervix the nipples healed.

**Curetting.**—Dr. Jno. L. Hanchett.—As to the matter of curetting, I have made a study of it and have made the moderate assertion that within fifty years it will be common practice, about the eighth day after confinement, to make a careful examination of the cervix to see if there is any yellow, slimy discharge coming from it. These cases, or those showing moderate temperature, will be carefully curetted. The more I use the curette the less trouble I have ; I have never yet had any trouble from curetting. As to the sac of waters : I was taught that it was a very valuable thing in confinement, but experience has taught me that it is of comparatively little importance, as the head frequently comes down while the waters go back. We have attributed undue importance to the sac of waters.

***Delivery through a Central Rupture of the Perineum.***—Dr. A. Sitzinski (Edin. Med. Jour.) says central rupture of the perineum is rare, and delivery of the fetus and placenta through the tear is still rarer. He then relates a case of this kind concerning which a communication had been made to the St. Petersburg Obstetrical and Gynecological Society. The patient was twenty-six years of age, and a primipara ; her pregnancy had pursued a normal course. The head presented in the first posi-



tion, and in due course appeared at the vulvar aperture. There was great protrusion of the perineum and of the anus. Fearing a rupture the midwife made two lateral incisions one centimeter in depth into the perineum. Soon thereafter she was surprised to find under her hand the child's face showing through a central rupture in the perineum just in front of the anal aperture. The head soon passed through the rent, and was followed by the trunk, and ten minutes later by the placenta. From the beginning of the pains the labor had lasted twelve hours, the second stage being one hour in length. The child was of more than average size, measuring fifty-one centimeters in length, and weighing 3650 grams. The enormous central tear in the perineum had an irregularly quadrangular form, its upper border was the posterior vulvar commissure, and its lower one the boundary between the skin and mucous membrane at the anal ring. In order to repair the rupture the posterior vulvar commissure was cut through in the middle line, and then the parts were brought together as in the operation of colpo-perineorrhaphy, first the tear in the posterior vaginal wall being closed, and then that in the rectum. With the exception of a small recto-vaginal fistula the parts healed well, and both mother and child left the hospital three weeks after labor.

**Brow Presentation: Internal Manipulation.**—Dr. Schuel (Archives de Tocol. et Gynéc.) reports a case which shows how in brow presentation its conversion into a vertex presentation by pressure of the finger or fingers is apt to be persistently reversed directly the finger is removed. In his case the patient had a capacious pelvis. The abnormal position of the head was rectified at the inlet, the membranes burst, but the brow came forward again. For half an hour the finger was kept against the head, but the latter did not become engaged in the pelvis. Schuhl therefore removed his hand. Five minutes later the head was found engaged in the pelvis, but the brow again presented. The mouth was open, the chin could not be reached. Within ten minutes the head was expelled, a live male child being expelled naturally. In this particular case, Schuhl observes the pelvis was capacious and the fetus' mouth was open. Polosson has already shown that this is, for mechanical reasons, an advan-

tage in brow presentations. This case, however, shows that in general it is useless to try to "convert" a brow presentation when the head is still at the inlet.

**Induction of Premature Labor.**—Dr. Solovieff (Répert. Univ. d'Obstét. et de Gynéc.,) states that out of 290 labors in the Moscow Maternity induction of premature labor for general pelvic contraction was found needful in twelve cases. The labor was brought on between the thirty-sixth and thirty-eighth week of gestation. All the women recovered, but seven of the infants were lost. This enormous mortality is due, Solovieff believes, to individual predisposition on the part of the fetus. In the interests of the child the forceps or turning is best. The integrity of the membranes is of the highest importance for its safety. Contracted pelvis is always unfavorable for the fetus; slipping up of the arm and compression of the cord are both frequent under this complication. The mortality of the children, however, Solovieff thinks, should not be a contra-indication to induction of premature labor, for it is much less serious than symphyseotomy. Marduel successfully practiced the induction of labor in the second, third, and fourth pregnancies of a young woman whose first labor was very lingering, and was terminated with difficulty by the forceps. The second labor was induced at the eighth month by Tarnier's bags, and a living female child was delivered without forceps. The true conjugate was  $3\frac{1}{8}$  inches. The third was induced a little later (not quite eight and a quarter months). The patient disliked the prospect of the dilating bags. The bougie was introduced, and after dilatation the forceps was applied, as the patient was weak, a living male child being delivered. The fourth labor was induced at about the same stage as the third, also by the bougie, and a female child successfully delivered without the aid of forceps. In this case the child was larger than in the preceding delivery. Its head, Marduel believes, molded itself more readily. He used, it is noted, a little manipulation to assist delivery. Marduel thinks that the introduction of the bougie is undoubtedly the right way to induce labor. Tarnier's bag is sometimes expelled before it has time to dilate the cervix sufficiently. Champetier de Ribes' bag is apt to displace the fetus so as to change the presentation. Kiwisch's

vaginal irrigation is tedious and uncertain. Marduel has seen alarming symptoms follow this practice. He thinks that induction of premature labor is right under conditions where symphyseotomy is impossible or unjustifiable, as in private practice. Symphyseotomy is a hospital operation, and requires first-rate assistance, an ample supply of instruments, and many appliances not often at hand in practice.

**Symphyseotomy.**—Dr. Noble (Trans. American Gynec. Soc.) describes a case of a woman whose pelvic measurements were as follows: external conjugate,  $6\frac{3}{4}$  inches; diagonal conjugate,  $3\frac{1}{8}$  inches; conjugata vera (estimated),  $2\frac{7}{8}$  inches. At her first labor the child died soon after birth from damage due to the forceps. A very small child was delivered spontaneously at the end of the second pregnancy. The third labor was a Cæsarean section done by Howard Kelly, with delivery of a child weighing  $6\frac{1}{4}$  lbs. The fourth labor was induced five weeks before term by Kelly and Noble, and a female child weighing 5 lbs. was delivered by the long forceps with great difficulty. Remembering these difficulties, Noble let the next pregnancy go on to term, and performed symphyseotomy on December 5, 1892, delivering a male child over 8 lbs. in weight by aid of the long forceps. The mother was delivered a second time by symphyseotomy and the application of the forceps on March 19, 1894. The child, a girl, weighed  $6\frac{3}{4}$  lbs. The mother recovered without any other incident than a mammary abscess.

**The Curette in Puerperal Infection.**—Dr. Ferre, Nouvelles Archives d'Obstet. et de Gynec., strongly supports this practice after long experience of irrigation of the uterine cavity for puerperal infection, a procedure which lowered mortality but did not save several bad cases. At the same time he never had recourse to the curette after labor excepting when placental relics required removal. Since using the curette six bad cases had been treated by Ferre, with only one death. The fatal case, it must be noted, was a private patient, and symptoms of infection immediately followed natural labor at term; she was left without assistance for five days, and the curette was employed as a last resource. The patient died on the seventeenth day. In a second private case the curette was used on the second day immediately after a rise

of temperature with rigors. The symptoms of infection at once vanished. In a third a live child was born; a twin then presented at the shoulder. Embryotomy had to be performed. Fever set in on the same evening; next day large blunt curettes were used, without anæsthetics, the uterine cavity was swabbed with glycerin of creasote and plugged with iodoform gauze. All bad symptoms ceased at once. The three remaining cases were in the *Pau Lying-in Hospital*, and had all the advantages of treatment in a public institution. They resembled the second above described, except that in one case parametritis set in before the curette could be used. All recovered.

***Diet During Pregnancy.***—A writer in the *Rev. du Their*. thinks many of the ills which accompany parturition are brought about by improper diet during pregnancy. An excess of water and albuminous food should be avoided—water, on account of its tendency to produce hydramnion and albumin, because it favors excessive growth of the child.

The following is the diet prescribed, and which has been tried in a number of cases:

Meat once a day, green vegetables and potatoes; avoid eggs, peas, and beans, as they are too rich in albumin. Wine and beer may be taken in moderation, but no more fluid should be taken than necessary. The advantages claimed for this regimen are:

1. The patients are active until the eve of their accouchement; they do not suffer from a sensation of fullness, excessive formation of fat, thirst, or constipation.

2. Rapid and easy delivery, even in those cases in which the previous labors have been prolonged and difficult.

3. There is never an excess of liquor amnii.

4. All the women thus dieted have nursed their babies. The quantity and quality of the milk were always good. The children were small, but healthy and well formed. They averaged about six pounds in weight; the circumference of their heads about 33.4 c.m.

***Pregnancy in Apparently Imperforate Hymen.***—Dr. Braun (*Centralbl. f. Gynäk.*) was consulted by a newly married woman who had found herself unfit for complete connection. He examined and found a virginal appearance of the external parts, a

tight and narrow hymen, and pregnancy advanced to the fifth month. The patient had a generally contracted infundibuliform pelvis, and craniotomy was needed at the end of pregnancy. Braun notes that penetration must have been impossible in this case, where pregnancy occurred before the patient suspected it.

***Pregnancy with Unruptured Hymen.***—Dr. Guerard (Centralb. f. Gyn.) relates three new cases of pregnancy in which the hymen was persistent. In the first and second there was a protracted second stage due to the resistance of the hymen, which was perfect and very elastic. After crucial incision the fetus was at once delivered, but in one case the child was lost. In the third case the patient appeared to be in the seventh month of her first pregnancy, and suffered from severe pains in the genital tract. Although she had twice been operated on for atresia of the hymen, the vagina was still closed by a firm, impermeable, and tender membrane. This was excised, the pains disappeared, and the pregnancy continued and ended naturally. Guerard notes a case of bifenestrated hymen where the openings barely admitted a hair; yet the patient reached the third month of pregnancy, and abortion was induced in a manner which could not be ascertained. In considering these cases, he notes how the alkaline uterine mucus, poured out during orgasm, protects the spermatozoa from destruction by vaginal mucus.

***The Couvade in Kentucky.***—According to Dr. T. S. Bullock, the belief underlying the couvade still (Amer. Pract. and News) survives in Kentucky. The husband is "commiserated" with on account of "morning sickness." The couvade was an obstetric custom, which resulted when the child's right of inheritance passed, in the course of evolution, from the mother to the father, who was henceforth supposed to have a secret, yet intimate, connection with the unborn and recently born child. The father was believed to enter intimately into all the ailments incident on pregnancy. In Yorkshire, when an illegitimate child is born, it is a point of honor with the girl not to reveal the father, but the mother of the girl goes out to look for him, and the first man she finds keeping his bed is he. The couvade was known in Ireland, at least in Ulster, and when the great invasion of that province took place under the leadership of Ailill and Mebb, with their

Firbolge and other forces, they found that all the adult males of the Kingdom of Conchobar MacNessa were laid up so that none of them could stir hand or foot to defend his country against invasion, excepting Cuchulainn and his father alone.

*Diagnosis and Treatment of Extra-uterine Pregnancy.*—Dr. Chaput (Sem. Méd.) concludes that (1) the differential diagnosis between hematocele and pyosalpinx was usually difficult; (2) non-ruptured extra-uterine pregnancy before the fifth month can only be suspected; (3) in extra-uterine pregnancy complicated by non-encysted hemorrhage surgeons are unanimous as to the proper treatment being immediate laparotomy; (4) in encysted hematocele or effusion the choice lies between (a) laparotomy, (b) incision per vaginam. The latter is far from being free from danger, and the author always performed laparotomy if hematocele resisted ordinary medical treatment. Even if it is first discovered on making a vaginal hysterectomy or puncture he would perform laparotomy, which makes it possible to take away the ovum and placenta, and stop bleeding. In the discussion which followed Bouilly thought that in any case of extra-uterine pregnancy one had to do with an abdominal tumor which indicated laparotomy. Laparotomy is also indicated when sudden alarming symptoms make one suspect rupture of extra-uterine pregnancy. The symptoms of hematocele from rupture of extra-uterine pregnancy usually make the diagnosis easy; suppression of menses, suddenness of onset of symptoms, more or less peritonitis, and development of tumor in Douglas' pouch. Incision through the posterior cul-de-sac is the best treatment. Bouilly had performed thirteen cases with the best results. Tuffier thought the diagnosis of rupture by no means easy. Out of four cases seen by him he mistook the first for acute peritonitis from perforation; in the second no diagnosis was made. He agreed with Bouilly that incision through the posterior cul-de-sac was the best treatment of simple or suppurating hematocele. Reynier and Terrier, however, limit vaginal incision to septic cases, performing laparotomy in all recent ones, which allows the operator to see what he is doing, and to remove diseased appendages if necessary.

## Gynecological Etchings.

**Placental Circulation and Morphinomania.**—Dr. Bureau (Report. Universal d'Obstét. et de Gynéc) attended a patient who had taken morphine for seven years, and who when he saw her took as much as 15 grains of that alkaloid daily. She was pregnant for the fourth time. At length she was spontaneously delivered of a child with talipes of one foot. As the cord was divided Bureau collected the blood of the placenta and umbilical vessels. On chemical analysis morphine was detected in the blood.

**Foreign Bodies in the Uterus.**—Dr. Albertin (Provence Méd.) collects twenty-four cases. Two are original. In one case a laminaria tent remained nearly eleven months in the uterine cavity, and in the second a carbon rheophore was left behind, and did not come away for a week. In neither instance was there any symptom of irritation, and both the tent and the rheophore were expelled spontaneously.

**Asepsis and Antisepsis.**—Dr. Leavitt.—I believe that antisepsis has come to stay. We must learn to distinguish between asepsis and antisepsis. While in England, some years ago, I had a desire to see some of Tait's work. He was opposed to antisepsis, and I believe that he was sincere in his opinions. I have seen him come in from the country with horsehair and dust on his hands, and, with very little preparation, go into the operating room and perform two or three laparotomies. His assistants were required to wash their hands in an ordinary wash bowl and slap on a rubber apron; then he would come into the room in a few minutes, wash his hands in the same bowl, pour a little turpentine on his hands, and go to work. I saw him do that time and again, but now Tait's methods are a thing of the past; you will hear no more of them. In reference to the sterilization of catgut, cut the catgut into strands, place them in envelopes, and put into sterilizer, and have the heat gradually raised up to 200° F., where it may be retained for three or four hours. Catgut

prepared in this way is not brittle, and can be used without putting it into any solution whatever.

**The Root of Antisepsis.**—Dr. M. H. Parmelee.—Tait's idea of cleanliness strikes at the very root of the whole matter. There is an idea prevalent that, if you operate under antiseptic conditions, you are bound to use some irrigating agent. That is not true. What is antisepsis, if it is not cleanliness? In my estimation, cleanliness is the greatest thing to be observed in the operating room, and soap is the greatest antiseptic in the world. After the method of Fibron, the true mechanical removal of the germs is better than any chemical application. Now as to catgut: This is a subject always present in the mind of a surgeon. Dr. Edebohls uses what he calls forty-day catgut. He puts catgut in a locker, adds bichromate of potash, and presses it down into a screw-cap receptacle, and sterilizes it at a temperature of 265° F. for four or five days under this pressure, and then puts the catgut in a receptacle, and never opens it until ready to use. In that way catgut will last for forty days in the abdominal wall.

**Bichloride of Mercury as an Antiseptic.**—Dr. L. K. Maxwell.—I believe that some patients are too susceptible to this drug to have it applied in the strength 1-1000 the night previous to operating. If we apply a compress of this strength twelve hours previous to the operation, we are liable at times to be very much chagrined to find a very extensive dermatitis, and be compelled to wait for a week to ten days before we can do our operation. Last fall I sent a patient to the Toledo Hospital to operate for cancer of the breast. The patient was prepared about 9 P. M. in the above manner, and I went to operate at 10 A. M. the next morning. When we removed the compress, I found such an extensive dermatitis extending over the breast and one-third of the arm, that I was required to wait ten days before I could get her in shape to operate. I consider that to use this drug in the strength of 1-5000 is much safer.

**Personal Antisepsis.**—Dr. W. E. Green.—I want to say that before I do an operation, I am as careful to prepare my person as I can be. I always take a bath in the morning; remove all clothes which I have worn, and put on clothes which have been sterilized;

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then I put a bandage around my head, so that no hair is exposed. No man can operate aseptically who leaves the clothes on which he has worn in visiting other cases. No man can ride for miles in his buggy, and visit all kinds of cases, without having his clothes and person contaminated. I will not allow any person to come into my operating room who has not been thoroughly prepared. I am sure these principles can be indorsed by all surgeons of experience.

***Sexual Anomalies in Women.***—Dr. Novak of Christiana states that, independent of impotence and sterility, there exists an absence (as Hammond has pointed out) of volupity, but little discussed by gynecologists, although it may produce serious results in married life. There is a distinction between sexual instinct and the sense of the sexual orgasm. Sexual instinct depends upon psychical impressions reflected to the genital organs; while sexual feeling produced by a local irritation of the genitals has much less intensity. Want of sexual feeling is usually due to some central nervous system trouble. It may be absent in a woman in whom the sexual organs are perfectly normal, or cases of congenital or acquired malformation, especially where the clitoris is absent. Sexual feeling may be present or absent in absolute amenorrhœa. It was present in ten of fourteen cases observed. Congenital absence of the sexual feeling is comparatively rare. The trouble is acquired much more frequently than is usually believed. It is seen especially in the newly married, and in hysteric individuals. Contrary to the ordinary opinion, hysterics do not, as a rule, have strong sexual feeling, although they are very desirous of attention from the other sex. Intense brain work and violent emotion, which depresses the individual, exert a depressing effect on the volupity. The same is true of continuous sedentary employment, too rich food, and too great obesity. Inability to enjoy the sexual orgasm has the following causes: Psychical—want of personal sympathy with the man; excessive masturbation; abnormalities in the woman, whereby the sexual act produces painful congestion of the genital organs, and the normal relaxation does not take place; exhaustion of the nervous system from sexual excesses, and, finally, painful genital condition. Treatment for most cases is absolute

continence. The exhausted nerve centers should not be excited by the imagination. Temporary separation from the husband is most important. Tonic and quieting drugs can be used.

**Local Damage in Criminal Abortion.**—Dr. Haberda (Vierteljahrschrift f. gerichtlich. Medicin) finds that the damage to the soft parts inflicted in criminal attempts at abortion is usually quite characteristic. This is especially the case when undertaken by persons not instructed in anatomy or obstetrics. Even an experienced midwife or practitioner is apt to use force, as steps for legitimately inducing premature labor are slow and methodical, and hence likely to attract too much attention. The damage to the cervix is usually a groove-shaped rent, while depressions are found in the uterus, which sometimes mark a complete perforation. But a long narrow canal running through the uterine wall is particularly characteristic, indicating, of course, perforation by a pointed instrument. Damage to the vagina is less common. The cervix is occasionally found torn off from its vaginal attachment to the posterior fornix. In one such case a canal, clearly artificial, was found to lead from the torn point on the surface of the cervix to the internal os. In one case a perforating instrument had been thrust into the urethra and damaged the bladder, causing peritonitis. Another shows the blind violence often used in these criminal proceedings: Perforation of the anterior wall of the rectum, the vagina, bladder, and several coils of small intestine was detected.

**Medicine, or the Knife?**—Dr. T. F. Allen.—Supposing that I get a cancer. Must I immediately go and get it cut out? Is that my chance of life? One gentleman has saved one hundred per cent. of his cases by surgical measures. In old times a gentleman would get up in an assembly and say he had had hundreds of cases of diphtheria and never lost one. I wouldn't accept that; the gentleman has not yet had enough experience. I read of statistics of ten per cent. or fifteen per cent., as I get them from allopathic sources, especially of cancer of the uterus, in which, after say five years, they have not returned, and I am glad to see that percentage. I do not know yet that homeopathic treatment will equal that even; and I am sure it will not equal twenty-five per cent., as some surgeons claim and

some gynecologists claim. But I am not yet satisfied that the early removal of cancer is the proper course. It is not well established that cancer is a local disease. We will give you the benefit of the doubt; we will do everything we can, but it is not yet proved that it is local, and I am not entirely neglectful of the statements of pathologists. I am one of the men who want to know things and want to know exactly what to do. A woman has got an induration of the cervix and we think there is scirrhus degeneration going on, or an epithelioma. I think it is more likely to be a local disease; but it is terrible when a woman dies, and by inches; and, to save yourself, you have not done your duty. I want to know. I want to know for the benefit of my patients. It is not homeopathy with me; it is the saving of life. I stand on that ground. When they say sometimes, "Do the best we can," I do not think it always means surgery; I think it sometimes means homeopathy. It is a question between the best medical treatment and surgical treatment. When the surgeon says, "You have lost your chance and killed your patient," I can't stand it and sleep nights. If I am wrong in this matter, to let my patient go on in this way, I want to know it; but statistics of one hundred per cent. do not convince me.

***Pregnancy and Operations on the Appendages.***—Délagenière, Archives Provinciales de Chirurgie, has performed three operations for diseases of the appendages in pregnant women, and all were afterward delivered at term. In Case I. the patient was three months pregnant, and was seized with symptoms of peritonitis. After the symptoms subsided a tumor was discovered. An operation was performed; an adherent ovarian cyst with twisted pedicle was discovered and removed. In Case III. an ovarian dermoid was removed at the fifth month, as it had grown very large. In the second case there was disease of the tube and ovary on both sides, and the patient at the fifth month was exhausted from pain. The abdomen was very tender. The appendages adhered to the uterus, and the intestines around them were also adherent. Both tubes and ovaries were removed. There was great trouble during convalescence owing to constipation. The patient was afterward delivered at term of a healthy infant. A few hours later she felt severe pain close to the right

side of the uterus, and there was nausea with pallor. All the trouble passed away at the end of an hour. A year later the patient was in excellent health. He concludes that pregnancy need never modify the indication to operate. It is a complication of the existing disease, rendering operation all the more necessary if not urgent.

**Cervical Canal During Menstruation.**—Dr. Herman, Arch. of Gyn., says: A great difference of opinion prevails as to the state of the uterine canal during menstruation, some saying that the canal is made smaller by swelling of the mucous membrane, others maintaining that it dilates. All of these opinions, however, are mostly based on theory, and but little on direct observation. I have carried out a series of careful measurements of the cervical canal during menstruation, and I have arrived at the following conclusions: (1) That slight spontaneous dilatation of the cervical canal takes place during menstruation; (2) that this dilatation is at its maximum on the third and fourth days of menstruation; and (3) that this dilatation takes place in those who menstruate with pain as well as in those who menstruate without, in those who menstruate scantily as well as in those who menstruate copiously; and there is no marked concomitant variation between the amount of dilatation and the amount of pain, or the amount of the flow.

**Uterine Gonorrhea.**—Dr. Wertheim (Centralbl. f. Gynäk.) believes that next to the urethra the uterus is the most common seat of gonorrhea. The germ sets up true acute interstitial endometritis; in chronic disease the glandular tissue of the endometrium is greatly increased. The muscular coat is often involved, and a kind of sclerosis of the vessels occurs, while the connective tissue undergoes hyperplasia at the cost of the muscle cells. Gonococci are usually to be found in the inflamed mucosa, yet sometimes they are entirely absent and they rarely, if ever, can be detected in the exudations in the muscular coat. The os internum offers no protection to the entrance of gonorrheal poison into the uterine cavity. The cervix is less involved, and the disease is always least marked nearest the os externum. The puerperium is the most dangerous condition when gonorrhea exists in the genital tract lower than the uterus. Menstruation,

coitus, and the sound are much less liable to expose the uterine cavity to gonorrheal infection.

**Cancer, Tuberculosis, Bright's Disease.**—Dr. Genevieve •Tucker.—All through Colorado the medical profession, both homeopathic and allopathic, see this: that the persons sent there for tuberculosis, who improve, frequently, in twelve to fifteen years, develop either cancer or Bright's disease: the men will frequently have Bright's disease, while the women will have cancer; and invariably in those cancer cases we will find a traumatism.

Three years ago there walked into my office a magnificent looking woman who gave me this history, that twelve years ago she had come there for tuberculosis; being told that, if she did not improve, she could not live one year. The improvement was rapid. She was approaching the menopause. In the meantime she had borne three children and had a traumatism of the cervix. I was horrified when I made an examination. I at that time was fresh from post-graduate study in New York city; I had seen much of operations and knew when to operate. It had been pointed out to me that these cases should be operated on at once. I do not know a surgeon, allopath or homeopath, that I could have taken the case to but who would have said, operate immediately. I had had such constitutional trouble brought up to me in the history of the case that I feared an operation would not do any permanent good. I walked my office half the night to decide on two things: whether I was going to abuse that patient by trying to give her medical treatment and trying to cure something that was not curable; or whether I was not doing an injustice to my patient in not referring her at once to a surgeon. I decided from the constitutional symptoms she presented to give a remedy, and I hunted my materia medica for the remedy. Natrum sulph. was given in a twelfth. In a few weeks after that I had an outing in the mountains with this woman. We came in contact with a prominent physician of the States. He said to me one day, "You have a woman with you who has a cancer." The first improvement was followed by the growth of an old goiter that she had forgotten about ever since she left Lafayette, Ind., years ago. The progress in the uterine trouble has been in proportion to the aggravation of the goiter. I do not know to-day where I could take this woman to any allopathic surgeon or any homeopathic

surgeon, who would think of an operation for cancer. I have repeated the remedy only when I found the goiter was going. We keep a daily history of that goiter.

**Ætiology of Cancer.**—Dr. Wood.—I do not believe that cancer, at its beginning, is a constitutional disease. It has all the characteristics of a local affection at the very beginning ; and according to the very best statistics which we have upon this subject, heredity has only been traced in about seven per cent. of these cases. I don't know what the cancer is, whether it has an embryonic origin or parasitic, a nidus for the entrance and multiplication of parasites ; but facts speak louder than theories. There are thousands of cases of cancer of the uterus, of the breast, and all portions of the body, where they have been removed, which have been proved to be such by the microscope, which have remained perfectly well for years ; and we are increasing our percentage of cures right along, as we are learning to make the more destructive operations, cutting wide of the mark, and as we are getting the diseases earlier before they become constitutional by tinkering and relying upon the constitutional remedies. I believe that cancer of the uterus, in at least ninety-nine per cent. of the cases, is associated, according to the best statistics we have, with child-bearing, bruises, and with lacerations and injuries of the cervix : and if you will let us expert gynecologists repair these injuries in time, we are going to prevent these cancers in a very large proportion of the cases. About ninety-nine per cent. of the cases of cancer of the uterus follow in the train of child-bearing. If you repair the cervix, you remove the cause, you leave the woman in as natural and calm a state as possible, and you are going to prevent cancer in a very large per cent. Every woman who has a laceration of the cervix ought to have it repaired for the purpose of preventing malignancy, if for no other purpose.

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## PEDIATRICS.

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**Prognosis of Heart Disease in Children.**—Dr. Chapman, —Lancet.—Difficult as it most generally is to forecast the issue of a case of heart disease, the anxious parents expect to be told

when and how far the child may recover and, if recovery is impossible, the probable duration of life. It behooves us, therefore, to answer these questions as far as possible. A diagnosis having been made of the physical condition of the heart, what are the data on which to form our prognosis? 1. If the cardiac disease was caused by a single attack of rheumatic fever, how long is it since the attack and what has the health been in the interval? 2. If there have been two or more rheumatic attacks, at what intervals have they occurred? 3. The family history. 4. What is the condition of the patient as regards general nutrition? 5. Is there good compensation, or commencing or even advanced failure? 6. If there is heart failure, is it recent or only a stage further on the downward course? The condition of the heart, lungs, liver, and kidneys will help materially in answering this question. 7. Oedema of the ankles.

Accuracy of diagnosis should always be aimed at, and in many cases repeated examinations are required to attain this object. If a long time—say, five or more years—has elapsed since the heart affection began we are able to judge how far the heart and circulation have accommodated themselves to the altered condition, and from the way the heart has borne the strain to form some idea how it will bear it in the future. Frequent recurrence of rheumatism at short intervals is always a bad sign. The extent of dilatation will be an index of the healthiness or otherwise of the myocardium and the muscular power by the regularity and strength of the heart's action, and its efficiency as a pump may be gauged by the condition of the pulse and other signs. Aortic stenosis of moderate extent is the least serious condition; the amount of hypertrophy of the left ventricle will be a guide to its extent. Aortic regurgitation may be so far compensated for as to render its existence but little bar to the enjoyment of life, although patients so affected cannot expect length of days. Anything which provokes dilatation brings the cases a stage nearer the fatal issue, besides which fatal failure of the heart may occur any time.

***Diphtheria Bacillus and Fibrinous Rhinitis.***—Drs. Gerber and Podack, Deut. Arch. f. klin. Med., demonstrated by cultures and by experiments on animals the presence of virulent diph-

theria bacilli in five cases of fibrinous rhinitis, which were all accompanied by definite constitutional disturbances. The membrane in the nose lasted on an average eight to fourteen days. As regards the accompanying throat affection, in two cases there was simple sore throat, in two others circumscribed blocked follicles in the tonsils without inflammation; in one case, two and a half weeks after the commencement of the nasal affection, typical throat diphtheria supervened. In addition to the diphtheria bacillus, streptococcus longus was also found regularly. In accordance with earlier observations, the authors believe that the existence of a true diphtheritic rhinitis fibrinosa has been proved. It is occasionally followed by severe general symptoms, infection of the pharynx and larynx, or post-diphtheritic paralysis. Its course is generally very chronic. True diphtheria may be conveyed by rhinitis fibrinosa, as in one of the cases investigated, in which the patient and her daughter contracted diphtheria, though the mother's nose at the time only showed the pseudo-diphtheritic bacillus. The pseudo-diphtheritic bacillus may be found in true diphtheritic nasal affections fifty to eighty days after the commencement of the disease, and also in old atrophic rhinitis. The authors do not, however, regard it as proven that a definite relationship exists between the pseudo and the true diphtheritic bacillus.

**Gonorrhea in Children.**—Dr. Fisher (Deut. med. Wochnschr.) relates the history of an endemically acting series of gonorrhea cases occurring in the Altona Hospital. Of fifty-four cases of vulvo-vaginitis in young girls, fifty were found to be cases of true gonorrhea. Of these, in only one case was the infection due to direct contact, this one case being the result of attempted coitus. Dr. Fisher relates that for some years the disease had been endemic in the hospital, but that the exact mode of transmission had not been discovered.

Vulvo-vaginitis in children is often due to some other form of infection besides that of gonorrhea, and it often occurs spontaneously from some low general condition in the child. Medico-legal questions often arise in this connection, wherein the reputation as well as the liberty of some innocent party may be jeopardized. Cases of seemingly true gonorrhea in children, with the specific



gonococcus, have been observed wherein there was an utter absence of infection from any outside sources. A urethritis with the production of the gonococcus has been induced by the injection of ammonia in the urethra.

***Gonorrheal Rheumatism in the Newly Born.***—Dr. Cuthbertson.—Ped.—The child was born on August 17, 1895, and two days afterward developed a severe purulent ophthalmia. The mother had a leucorrhœa for three months before the child was born, and the father had a gonorrhea, which was apparently well at the time of the child's birth.

The eyelids were greatly swollen and distended with pus. They were washed hourly with a saturated solution in water of boracic acid; then an application of a two per cent. solution of nitrate of silver was made; and finally they were washed with a normal salt solution. In five days the eyes were perfectly clear and the lids were nearly normal.

Four days after birth the nurse noticed that the child screamed when its arms or legs were moved. Finally the wrists, elbows, and knees became swollen and red, and it was evidently suffering from an acute gonorrheal rheumatism.

It died on the seventh day from a septic entero-colitis.

***Intussusception in a Child Treated by Insufflation of Air Under an Anæsthetic.***—Dr. H. Swift (Australasian Medical Gazette) reports the case of a child of nine months who had always been healthy, but who suddenly began to scream violently, draw its legs up and kick them out as if in great pain. Vomiting occurred several times. No tumor could be detected in the abdomen. Temperature normal; pulse increased. That evening the child was worse, collapsed, retching violently, screaming, and had passed some blood and mucus by the bowel. Intussusception was diagnosed, chloroform administered and air insufflated into the lower bowel, and a tumor which had been detected, after the child had been anæsthetized, above and a little to right of the umbilicus, and which was about three inches long and two broad, with its axis lying transversely, was kneaded while the insufflation was continued. A gurgling sound was heard and the enlargement was found to have disappeared.

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Fig. XVII—Dorsal Position.

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W. P. England, M. D., White Pine, Pa., says: I have used Celerina and am pleased to say that in all cases of nervous prostration, such as follows the use of alcohol, and for all cases of nervous debility, I find it without an equal. After the experience I have had with it I do not hesitate in recommending it to the profession as one of our best nerve tonics.

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The action of Celerina on the brain and nervous system is that of an exhilarant and slight narcotic, relieving depressions and lessens irritable nerve conditions. In cases of organic and functional lesions of the heart, an increased steadiness of pulse-beat and diminution of pulse irritation is apparent.

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A. J. Wesco, M. D., Seven Mile, O., says: I have tested Celerina and got good results. Man, aged sixty-five years, mechanic, habits very intemperate, will spree for weeks, came to me with nervous system in bad fix; could not eat or sleep. Gave him eight ounces Celerina, teaspoonful three times a day, which placed him on his feet again, and for that I think it par excellence.

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Convulsions may frequently be cut short, like magic, by teaspoonful doses of Celerina repeated at short intervals. The nausea as an after-effect of chloroform or other narcotics, may generally be controlled in the same manner.

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T. J. Hall, M. D., Atlanta, Ga., says: Celerina has always acted finely in all cases where I have tried it, especially in those troublesome cases of hysteria, nervous depression and feebleness, and prostration resulting from alcoholic excess. Have found its effects very exhilarating and nourishing. In fact, it is my main dependence in all nervous diseases.

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The psychological depressions and neuralgias, so common in the period following a debauch, are lessened or disappear altogether by the use of Celerina.

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J. B. Johnson, M. D., 930 N St., Washington, D. C., says: I used Celerina not only as a nervine and tonic, but also found it most excellent, in two drachm doses, in sobering persons who were made drunk by alcoholic drink, and such patients informed me that they were greatly assisted in recovering from a spree by the use of Celerina.

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After the removal of alcohol, Celerina, given in doses of from one-half to one ounce every four hours, is speedily followed by the most characteristic symptoms of improvement.

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Dr. Bramwell, Whitley, Northumberland, England, says: I have found Celerina valuable as a nerve stimulant and restorative in a patient suffering from the effects of a severe drinking bout.

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ST. LOUIS, MO.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, B. F. UNDERWOOD, M. D.,  
102 Fulton Street, New York.

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## THE REPAIR OF THE CÆLIOTOMY WOUND.

BY HOMER I. OSTROM, M. D.

THE method of repairing the cæliotomy wound is of more importance than the method of making it.

It is assumed that both procedures are conducted upon the strictest aseptic principles, thus insuring primary union. When this is not obtained, the fault rests, *first*, with defective preparatory technique,—and in this I include, not only the preparation of the patient, the instruments, the surgeon, and his assistants, but also the most careful attention to the details of isolation during the entire manipulation,—and *second*, to the method of laying the sutures.

As the strength of a chain is measured by the resistance of its weakest link, so the strength of aseptic surgery depends upon the exactness with which each step, or link, in the chain of preparation and technique is carried out. If one of those links is weak, the work also is weak; if one is imperfect, the whole likewise suffers imperfection.

But as I have said, we will assume the absolute cleanliness of the operative field, and of the operation itself. In

these days our patients have a right to demand this, and we on our side should be satisfied with nothing less than a certain exclusion of any element that can increase the risk of our undertaking.

I think I have employed in my practice every method that has thus far been proposed for making and closing the cœliotomy wound. Elaborate dissection for one, and equally elaborate and complicated introduction of sutures for the other. In obtaining primary union I have rarely failed, and I think I have been rather fortunate, notwithstanding the very faulty methods that I have sometimes adopted, in having to place on record so small a percentage of scar hernias.

My present method of opening and closing the abdomen—subject, I wish to say, to change, in favor of something better should such present itself—is, with a single stroke of the knife, to cut through integument, fat, etc., down to the aponeurosis of the external oblique muscle. After pushing aside the deep layer of fascia, the *linea alba* comes into view. This is cut between forceps, and frequently at the same time the peritoneum is opened. If not, the peritoneum is raised away from the abdominal contents with forceps, and incised *to the extent of the external opening*. The proceeding thus far should consume less time than has been required in its description.

Now as to closing the wound.

*First.*—I am careful to draw down the omentum, which usually becomes displaced upward during any intra-abdominal manipulation. By this maneuver, I think I place an additional obstacle in the way of adhesions forming between parietal and intestinal peritoneum.

*Second.*—Here I believe lies the gist of the matter, the observance of which will do more than anything else to prevent hernia of the scar. *I am careful that like structures are brought into contact to form cicatricial tissue.* Our knowledge of the process of repair clearly points out the advan

tages to be derived from so doing, and in this instance experience and theory support each other, for we would expect, upon theoretical grounds, to obtain a more perfect reproduction of tissue between structures built up upon the same organic plan, and requiring the same pabulum for their support, than could take place between structures dissimilar in character, function, and metabolism.

The least complicated methods are the best in surgery, and it is not necessary, in order to bring like structures together in closing the abdomen, to resort to the elaborate suturing of individual tissues advocated by some surgeons. Two rows of sutures are in the majority of instances quite sufficient. The first of fine catgut will bring the peritoneum together. I prefer interrupted sutures, as less liable to pucker the line of union, and formerly used iron dyed silk for the peritoneal suture, not having been able to obtain catgut that I would trust antiseptically in the abdominal cavity. But now I have all my gut and silk prepared under my direction in my Private Hospital, and experience tells me that I can rely absolutely on both, for cleanliness and for durability.

The second row of sutures are of silkworm gut, made to include all the structures outside of the peritoneum, and are introduced without any attempt to produce cosmetic effects.

The object in sewing the peritoneum separately will be made plain by reference to the figures No. 1 and 2. When all the structures composing the abdominal wall are included in a single suture, the peritoneum, being rather full, and it being necessary to bring its endothelial surfaces together to insure union, is forced up between the fascia and the muscular layers in the form of a wedge, and thus prevents union between these structures. The scars or wounds united in this way are frequently composed only of integument and peritoneum, the fascia and muscular layers having been kept apart by the wedge of peritoneum.



On the other hand, when the peritoneum is united separately by buried catgut sutures, the abdomen is closed, and only a fine line exists when the sutures are applied. The fascia and muscles can then be accurately brought together with deep silkworm-gut sutures, for the greatest tension of

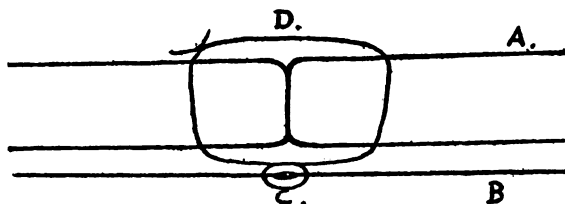


FIG. 1.—A, integument, muscles, and fascia; B, peritoneum; C, buried catgut sutures applied to peritoneum only; D, silk-worm gut sutures including integument, muscles, and fascia.

these structures being in the axis of the wound, there is no inclination for one tissue to force itself between the raw surfaces of another tissue.

For introducing silkworm-gut sutures in the abdominal walls, I use a long, very slender handle needle having a

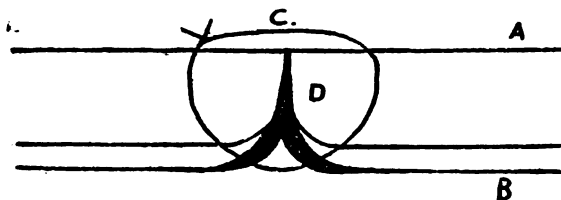


FIG. 2.—Integument, muscles, and fascia; B, Peritoneum; C, silk-worm gut sutures including entire abdominal wall; D, Wedge of peritoneum forced between muscular structures.

Hagerdorn point. The needle is only slightly curved at the end, for it is made to penetrate the structures almost perpendicularly down to the peritoneum. (Figure 3.) The sutures are set a full inch from the border of the wound, and because so much tissue is included within them a con-

siderable degree of tension is safe, with little danger of cutting off nourishment.

With the strict asepsis that I employ in all my operations the sutures give me no anxiety, and are usually left undis-



FIG. 3.

turbed for two, or more frequently three, weeks. They act as a splint to the healing tissues, and the longer they remain in position the less danger is there of stretching of the newly united structures.

I do not attach as much importance as formerly to the primary dressing of the cœliotomy wound. Any aseptic dressing will serve the purpose. I do, however, object to ointments, and to moist dressings, which I at one time favored. A lightly adjusted strip of iodoform gauze,—five per cent., the ten per cent. article is too strong,—with a sterilized cotton and gauze pad, adhesive straps, and a many-tailed flannel bandage, makes I think the more satisfactory dressing. The bandage should be changed daily.

The use of an abdominal supporter during convalescence belongs to the treatment of the cœliotomy wound, but so potent is tradition, that I fear we are prone to accept without question the opinions and practice of our teachers as to the length of time a belt should be worn. That the newly formed tissue needs support, seems to me to admit of no doubt. Scar tissue does not acquire the strength of mature tissue until it has passed through certain developmental phases, which consume a definite length of time, that cannot be shortened, and if even the natural intra-abdominal pressure is brought to bear upon this weak point, there is danger that it will stretch to such a degree as to impair the strength of the abdominal wall. On the other hand, if the

abdominal muscles are assisted in their function for too long a time, they lose their firmness, and strength, and become permanently disabled from supporting the contained viscera.

My experience leads me to conclude that the majority of surgeons favor too long wearing of the belt—there are a few who discard it altogether. It is not unusual for ladies suffering from pelvic troubles to consult me one or even two years after a coeliotomy performed by another surgeon, still wearing their abdominal belt. The condition in these cases, and the one to which the suffering can be referred, is one of general passive congestion of the pelvic and abdominal organs, the direct result of the artificial support they have so long depended upon. The abdominal muscles are flabby, and the entire pelvic and abdominal circulation, arterial, venous, and absorbent, enlarged, and able but imperfectly to carry on their several functions.

Such a use of the abdominal belt bears its own criticism. I believe, however, that the belt occupies a legitimate place in the after treatment of abdominal operations, and should not be discarded because of the abuses to which its use has been put. No hard and fast line can be drawn, however, for the length of time the belt is to be worn. Speaking generally I regard three months as the extreme limit, but much will depend upon the extent of the wound, the lax, or otherwise condition of the abdominal muscles, and the reparative status of the patient.



## PUERPERAL INFECTION.

BY JOHN J. SHAW, M. D.

IN considering the therapeutics of puerperal infection I cannot perhaps do better than to give a recent case.

Mrs. M., in labor with third child; the other confinements were natural. Was called at 5 A. M., found moderate pains about every ten minutes, os just within reach and slightly dilated. Went away and returned at 9 A. M., found pains somewhat more frequent and os as large as a quarter and dilating. By 10.30 the os was soft and dilatable, the head presenting, and everything looking favorable. At every pain, however, I found the bag of amniotic fluid forming behind the head so that the uterine contractions only served to drive the head against the pubic arch. At the next pain I therefore ruptured the sac and the head at once was forced back into the position the sac had occupied and became engaged in the superior pelvic strait.

The head progressed well until it began to press upon the urethra, when the patient began to complain of peculiarly unpleasant sensations in the urethra, these at each pain getting worse, and soon destroying all the efficiency of the pains.

Some ether now administered did not relieve. I therefore applied the forceps and after some quite hard work I delivered the head; I now found the cord twice around the neck and so short that it was extremely difficult to get slack enough to get it over the head. Succeeding at length, I addressed myself to delivering the shoulders. With extreme difficulty owing to their width, and with grave apprehension as to whether the infant could survive the lengthy ordeal, I finally succeeded. The child was asphyxiated, but I wiped the face, tickled the epiglottis, slapped the back with cold water, held it by the feet, inverted, and dilated the anal sphincter, and it rewarded me by breathing. It weighed thirteen pounds.

The uterus contracted on the placenta, and I waited with resultless attempts to assist expulsion at every special contraction, for a half hour, when the patient began to flow more than I considered safe. I therefore introduced my left hand, stripped to above the elbow, and found a closely adherent placenta. After careful and systematic work I removed it entire, and injected a syringe bulb full of hot vinegar and water. The uterus contracted well and there was no further hemorrhage.

The patient has always had a weak heart, and I gave her hot milk and water and china.

Her condition seemed good considering what she had passed through. All went well for one hour, then as I had stepped into the next room I heard her say she was sick to her stomach. I at once stepped to her side and found her pulseless. I removed all pillows from under her head, and looked for hemorrhage, but there was none, either external or internal. The uterus was well contracted. The trouble was evidently with the heart. I gave veratrum v. and stimulants. The pulse gradually improved and was fairly good after one hour. In the evening I catheterized and she passed a fairly comfortable night. Next morning I had the bed and patient's clothing thoroughly changed. Pulse quite rapid and temperature a little above normal. The second morning the temperature was 101.5° and the odor of discharges quite noticeable. I therefore gave her a thorough uterine douche of mercuric bichloride, 1-5000. As the flow was quite moderate I gave pulsatilla and china, with an occasional dose of lachesis. At night I gave a vaginal douche, of same strength.

The next morning the temperature was better but I repeated the uterine douche. After this time as the temperature was only 99° to 99.5°, she received twice daily a vaginal douche of the mercuric bichloride. This was continued for one week, when the temperature being normal it was discontinued. She received at various times veratrum v.,

hamamelis, and secale, and I had the bowels bathed with equal parts of spirits of turpentine and olive oil.

In treating this patient I used several remedies, including drugs and adjuvants, and it might be questioned whether after so doing I could tell with any degree of certainty what if any was the one effective point in the treatment.

But the object was cure, and that was accomplished.

I am confident, however, from theory and experience that what saved the patient was the uterine douche. That I consider indispensable as well as almost absolutely effective.

The other remedies are good but only as adjuncts.

In treating any disease the first and most important indication is to remove the cause. In many cases this cannot be done, but fortunately in cases of puerperal infection this can be effectually accomplished. Since the decaying debris of labor is usually the *causa morbi*, when once thoroughly removed, the change in the condition is immediate and marked.

In washing out the genital tract I use mercuric bichloride because I know of nothing that will take its place. While used in a strength which is comparatively safe it is still strong enough to destroy at once the infectious character of the contents of the uterus, if we do not succeed in washing it entirely away. It is almost if not quite as effective as curetting, and at the same time is not followed by so much constitutional disturbance.

It is generally my custom to give this douche twice daily until the temperature is below 100°, then once daily until it is not above 99°. I usually use about a quart of a 1-5000 or 6000 bichloride solution, and I always follow it with about a pint of boiled water. In this way I feel confident that I may prevent the danger of poisoning my patient. I have used it many times and have never seen any bad results. If this cleansing is done soon enough there will be no occasion for other remedies. If sufficient absorption has taken place so that the temperature does

not drop as it should, veratrum v. in  $1/3$  to  $1/5$  drop doses hourly is an efficient aid. The benefit of lachesis in counteracting the effect of septic infection cannot be questioned, and china or even quinia may be valuable in cases where there is a tendency to chills.

The administration of proper nourishment should not be overlooked. In many of these cases there is either pronounced nausea or a tendency thereto. When such is the case it may become quite difficult to induce the patient to take the requisite amount. Milk, or milk and egg beaten together are excellent, or where there is nausea some of the manufactured foods do well. Among these, Mellin's Food, Malted Milk, and especially Beef Peptonoids diluted to thinness by milk or water will often remain on the stomach when nothing else will, and when the stomach absolutely refuses nourishment, the Beef Peptonoids is one of our most effective means for rectal feeding. Most old school authors recommend alcoholic stimulants in comparatively large quantities. I do not use them except occasionally in case of collapse or much tendency thereto, and then only for a short time, until the urgent symptoms are past. Their continued administration seems to me to increase the fever without giving any compensating advantage.



## CONSTIPATION IN INFANCY AND CHILDHOOD.

BY JOSEPH PETTEE COBB, M. D.

CONSTIPATION is one of the most frequent and annoying pathological conditions of infancy and childhood. It is present as a symptom in the course of several diseases and at times is due to mechanical obstruction or imperfect fetal developments. This symptomatic form of constipation is not the subject I propose to discuss, but rather the idiopathic form where the constipation is the principal pathological condition.

In the child there are some marked anatomical peculiarities which favor the development of constipation. The small intestine is comparatively longer than in the adult, and its lumen is smaller; the ascending and transverse colon are shorter, while the descending colon is relatively longer. The pelvis is smaller and more contracted and the liver is relatively much larger than in the adult. As a result of these peculiarities the flexures and curves of the bowel are more pronounced and angular and the cul-de-sac of the sigmoid much deeper.

In the infant the muscular coat of the intestine is imperfectly developed and the natural peristalsis is feeble. The secretions of the intestinal tract are smaller in amounts, and bile, nature's purgative, is relatively smaller in amount. Absorption in a child's intestine is very active and a slight delay in the passage of the food allows too great an abstraction of liquid.

Older children are often fed upon food which is easily fermentable and the development of large amounts of gas favors constipation through paralyzing the muscular coat by persistent distension. Constipation may result from diarrhea, where atony of the intestinal muscle follows persistent irritation and congestion. A deprivation of water either by feeding the child upon too concentrated



food or as a result of too great a loss by the other eliminating organs is a potent cause of constipation. Excessive perspiration and polyuria, when persistent, are in this manner causal factors.

The character of the food apart from the amount of water has a marked influence. Careful investigations have shown that in infants about one-half of the fat present in milk may be found in the dejecta undigested. In other words, of the four per cent. of fat in milk about one-half of it is consumed in the infant's organism and the other half is used simply as a lubricant. Mothers' milk is more apt to be deficient in cream than in any other of its normal ingredients. A marked diminution in the amount of sugar is also found to favor constipation. In older children a diet which consists of foods that have little waste material favors constipation because the small amount of fecal matter excites only feeble peristalsis.

Habit also has an important bearing: the obtunding of the sensibility of the rectum by putting off the calls of nature leads to a condition where a loaded rectum excites no irritation; school-children who are forced to obey inflexible rules frequently suffer in this way through no error of their own. A fissure at the anus will, because of the pain accompanying defecation, often induce a child to suppress any desire and put off the act of evacuation as long as possible. Here again the excessive absorption increases the difficulty by changing the consistency of the fæces.

The effects of constipation, the symptoms produced by this condition, may be considered under two rather distinct types.

*First*, the irritation produced directly as the result of the retention and mechanical irritation. A continued irritation will often result in a congestion of the intestinal mucosa with an increased secretion and peristalsis; an active catharsis is produced and the intestine is unloaded: the excessive irritation when relieved gives place to a lessened

sensibility ; the same accumulation takes place again with the same results and we soon have an alternating condition of constipation and diarrhea. The congestion may go on to inflammation, the lymphoid tissue and the follicles become implicated and a condition of chronic follicular inflammation or even ulceration be established.

The irritation produced by the mechanical pressure may not be confined to the locality where the pressure exists, but traveling back to the abdominal plexi and ganglia may be reflected to distant organs and seriously impair their functional activity. Not only the intestinal muscle, but the abdominal muscles may be stimulated ; prolonged stimulation will result in spasm : in infants whose inhibitory centers are poorly developed, it is an easy matter for a prolonged irritation to call out a general spasmodic action of both voluntary and involuntary muscles.

Pressure by retained fecal matter may seriously affect the circulation in the abdominal and portal veins and give rise to some œdema of the lower limbs : it may cause partial obstruction of the biliary ducts and favor resorption of bile with its stigmata, by obstructing the evacuation of gases it may give rise to extreme distension, which will interfere with the action of the diaphragm and obstruct the venous circulation in the abdominal and thoracic viscera.

These results are familiar to you all and need only to be mentioned to have their value recognized.

The second class of effects produced by retention of fecal debris, viz.: those due to overabsorption, are not so commonly considered.

In all parts of our systems there are continually manufactured products which need to be eliminated : products which are noxious to our health and which in sufficiently large doses are toxic ; these products when not eliminated lead to auto-infection or auto-intoxication, and the results of such infection depend upon the character and amount of the compound retained within the system. Nowhere in our

economy are there manufactured so many and so noxious compounds, both physiological and adventitious, as in our intestinal tract. Over thirty varieties of micro-organisms have been observed in the healthy intestine and its contents; even the physiological varieties develop products which are toxic if they enter the circulation in sufficiently large doses. Their constant elimination is a necessity. Nature provides that when one eliminating organ is inactive its work shall be done by others, but whether the function of the intestinal tract is vicariously performed by the lungs, the skin, or the kidneys, the compounds which should have been eliminated by the intestine have either been absorbed through the intestinal mucosa or they have been retained in the circulatory vessels longer than it was intended that they should be.

The intestinal surface is to a high degree an eliminating organ, and an important part of its function is to rid the system of noxious compounds formed elsewhere. Constipation with consequent venous stasis seriously impairs this part of its work. The intestinal surface also possesses a great capability for absorption; while it usually exercises a degree of intelligence in its selection of material for absorption, it will under pressure absorb much more than it is ordinarily expected to abstract from its contents; it will take up compounds that are of no value, that are toxic, and which some other organ must be taxed to eliminate.

The results of this overabsorption are often more baneful and more persistent than the results produced by local mechanical irritation. A urine persistently loaded with compounds will irritate the mucous membrane of the urinary apparatus; some forms of cystitis, enuresis, and nephritic congestion will result from prolonged irritation.

The association of cutaneous eruptions, especially eczema, with constipation, finds its explanation in the extra work thrown upon this eliminating organ and the irritation produced by such over-work.

The general languor, furred tongue, headache, and foul breath are due to the noxious compounds which are retained within the system.

In this same manner an irritation of nerve centers by noxious compounds in the blood may be the cause of general eclamptic seizures.

In the treatment of constipation I recognize the value and invariably make use of our homeopathic remedies, especially such well-tried remedies like sulphur, nux vomica, silicea, calcarea, bryonia, lycopodium, and alumina. I do not wish for a moment to underrate their importance. I do wish, however, to point out a few other measures at least of equal value.

1. For nurslings the necessity of an excess of cream in their food.
2. For all children a liberal supply of water.
3. The inculcation of good habits and an invariable response to nature's promptings.
4. For older children the use of a diet not restricted to articles of food wholly or largely assimilable.
5. Massage and manipulation of the abdomen to stimulate a sluggish peristalsis and a sluggish abdominal circulation.



## CHLOROSIS AND PREPUTIAL ADHESIONS.

BY CORA SMITH EATON, M. D.

SOME cases among young women and girls under my care have suggested a relation between preputial adhesions and chlorosis. If the relation be more than coincidence and assume the significance of cause and effect, it is worthy of consideration.

It is certain that the relation is not universal, for chlorosis is comparatively rare while preputial adhesions in women are so frequent that the cases where the hood of the clitoris is completely free are exceptional.

If medicine and surgery were exact sciences, if two and two were the only way to make four, our work would be easy. Physicians are given a result, to find all the factors, and it is often no easy matter to solve the problem. The most reliable way is the diagnosis by exclusion. Given a condition, which is an effect, we must consider every possible cause. The purpose of this paper is to remind you, not that every case of chlorosis is caused by adhesions of the hood, not that every case which has adhesions will develop into chlorosis, but that preputial adhesions in young women should be considered one of the possible causes of chlorosis.

The logic of it is not far-fetched. The clitoris is a bunch of terminal nerves, the excitation of which causes a powerful effect on the female sexual organs. If this excitation becomes a permanent state, by reason of adhesions, the bad effects it can produce are many. One, is the inhibiting effect on the menstrual function, which can change the circulatory balance and then the composition of the blood itself. To trace the effect of any orificial irritation is to tell a story like "The House that Jack Built," and it is quite as fascinating.

To free the clitoris, the hood is put upon lateral tension by spreading the parts between the thumb and finger of the

left hand, then, with a sharp pointed probe in the right hand a firm cut is made downward in the line of adhesion on the one side the clitoris and the same on the other side. It will take three or four probings on each side to complete the work. If the patient is under full anæsthesia or under fair local anæsthesia, it can all be done at one sitting. If she is bearing it without anæsthesia it often takes three or four treatments, two or three days apart. Gas makes an excellent anæsthetic for this operation. It has been given in my office for this purpose by a neighboring dentist, about a dozen times.

The best dressing is sweet oil. The patient or attendant should be taught to retract the hood, and to cleanse the part thoroughly with warm water, and to apply sweet oil, night and morning, for several days to prevent re-adhesion. If no one else will do this, the doctor must attend to it personally.

Two cases, typical of the others in my experience, will serve to illustrate.

CASE I. Miss C. D., Norwegian, age nineteen, dressmaker for five years, now doing house work, seen first on December 3, 1895. Very pale, a greenish pallor, body plump, mucous membranes pale on eyelids, gums, and lips, not so pale in vagina and uterus but paler than normal. Flow absent for two or three months and then only a stain. Mind depressed, wants to cry all the time but does not know for what. She received puls. 3x and dialyzed iron 10 m. t. c. d., and four galvanic treatments with negative pole in uterus, positive on sacrum. The first treatment caused a faint show, but otherwise in ten days no improvement. December 13, patient under gas anæsthesia, the clitoris was thoroughly freed, the hood having been found firmly adherent and nearly covering the clitoris. For ten days it was dressed daily at the office, the hood being carefully retracted and the new adhesions, which almost always form, broken up and sweet oil applied. December 23, it was

well healed apart. December 26, there was a genuine effort at a flow. She received five more intra-uterine galvanic treatments, her color rapidly improving from the very day of the operation, and her general mental and physical state being much better. In February she reported continued improvement and a slight flow every month.

CASE II. August 19, 1895, called to see Miss N. H. Irish, aged eight years, a well developed child, but very pale, even the lips; abdomen bloated, blue circles under the eyes, frequently nauseated, pain in urination, no appetite, no strength, the mother sure her child would soon "die of a decline." Examination showed a mass of smegma, size of a pea, which was squeezed out from under the hood of the clitoris, the hood being adherent at what should be the free edge. Circumcision advised. On the next day, August 20, child under chloroform, after all adhesions were broken up, about half the hood was removed, and three catgut sutures were placed.

From the instant the child awoke from the anæsthetic her lips were rosy and her cheeks pink, and the bloating of the abdomen was gone. The mother's joy was unbounded. Four months later, when a beautiful little girl claimed my acquaintance, she had hard work to convince me she was N. H.



## CALCIUM BROMIDE IN CEREBRAL DISEASES OF CHILDHOOD.\*

BY J. J. MITCHELL, M. D.

**T**HOUGH I have been in the habit of using the bromide of calcium somewhat freely for several years in the various head troubles incident to childhood, yet I feel some diffidence in venturing to bring this drug to notice, and for the following reason: The pathogenetic symptoms produced by a medicine, when given to a healthy individual, should form the basis of the use of the same medicine in diseased conditions. In the case of calcium bromide I regret I have no such sure basis to rest upon, for I have been unable to discover any provings of this drug in homeopathic literature. Further, the only indications that I have any knowledge of, as to its medicinal uses, are to be found in a short article by Hale in his "New Remedies." Following the indications Hale has there laid down, the use of calcium bromide has given me for some considerable time past most gratifying results.

I will first of all call your attention to Dr. Hale's statements respecting calcium bromide, and then relate briefly some of my own experience in regard to its use. Dr. Hale lays special stress on the value of the drug in the cerebral diseases of childhood. He states that the children for whom calcium bromide proves most useful are the lax, lymphatic, nervous, and irritable; and that in children of this type we can by its use control the cerebral congestions and irritations to which they are subject, whether they are direct or reflexly caused. He asserts that with the aid of calcium bromide he has much greater confidence in the treatment of these conditions than in prescribing the much-vaunted belladonna, hyoscyamus, aconite, and bryonia. These remarks of Dr. Hale's I can fully indorse. In my

\* British Homeopathic Society.



experience of treatment with this drug I have used it with most success in children of the type mentioned—in children coming of a tuberculous stock, children in whom dentition is delayed and the fontanels close late, and who, in addition to head symptoms, exhibit other characteristics pointing to calcaria as a remedy.

These children perspire freely, especially about the head and when asleep, are thirsty, are often inclined to be rachitic, with a prominent square forehead. In cerebral troubles, with these characteristic symptoms present, calcium bromide almost invariably acts with efficiency and rapidity. The following is an example :

On October 12, I was called in to see a child aged nineteen months—born of delicate parents. The child had been feverish and restless at night for a week previous. For the last three days frequent twitchings of the limbs had been noticed, the head had been tender to the touch, the eyes intolerant of light, and yet never fully closed, even when asleep. Thirst was marked, but for water only, everything else being refused. On examination the head was larger than normal and especially prominent in front, the anterior fontanel not quite closed and a trifle full. Nine teeth were present. There was no sign of any tooth being cut, nor could any other source of reflex irritation be found. The temperature was  $100^{\circ}$  and the pulse very quick. Calcium bromide was prescribed every two hours. On the 13th the temperature was  $102^{\circ}$ , the pulse still rapid, the twitchings were much about the same, but the child had had a better night. On the 14th the temperature was  $99.2^{\circ}$ , the twitchings were less marked, the child had begun to notice more, and had had the best night since the commencement of the illness. The child was seen again two days later, when she was found sitting up and nearly as bright as usual. She had now begun to perspire somewhat about the head, a symptom previously absent.

I take this as an example of an early case of cerebral

congestion arrested by the use of bromide of calcium. But one often only comes in contact with cases of this type at a somewhat later stage, when convulsions and other urgent symptoms have supervened. On inquiry, as often as not, one finds that the child has been treated by its parents with poultices, under the impression that the little sufferer was ill with bronchitis, they (the parents) only beginning to suspect that the seat of the disease may be in the head on the occurrence of convulsions, when the doctor is hastily summoned. This mistake is one readily made by the uninitiated, owing to the fact that as the irritation of the brain becomes more intense the temperature rises higher, respiration is reflexly affected by spasm, a short dry cough is produced, and the frequency of respiration runs up to 50 or 60 per minute. These symptoms mask the brain origin of the mischief to some extent; but a diagnosis is easily made by stethoscopic examination of the chest, when no sign of any lesion can be discovered; and by closely watching the breathing, when it will be found that at intervals of a few minutes the respiration frequency will drop to 25 or 30 per minute, and continue at this slower rate for some time, thus showing the cerebral origin of this symptom. Yet I have on several occasions been called in to cases of this kind, which had previously been attended by another medical man, who had prescribed a jacket poultice and a steam kettle, under the evident impression that the lung was the offending organ. The train of symptoms above described also yield in the course of a few days to treatment by calcium bromide, prescribed at the onset, in alternation with aconite, belladonna, gelsemium, or veratrum viride, according to the character of the fever and state of the pulse. As soon as the temperature falls I discontinue the alternating medicine, and rely on calcium bromide alone.

Under this procedure the first thing to disappear is generally the rapid irregular respiration, and then the remain-

ing symptoms, usually in the inverse order to that in which they have appeared. The irritability, especially to light and sound, remains for a varying period, as do the perspirations about the head ; and these symptoms may necessitate treatment for some weeks before being finally got rid of.

For the notes of the following case, which is of an altogether different type to those I have already mentioned, I am indebted to Dr. Craig.

The patient, a boy of eight, was brought up from the country to see Dr. Craig on November 7, 1894. His mother stated that for some weeks she had noticed that he shambled in his walk and occasionally squinted, and that his sight seemed to be failing him. When seen there was present marked strabismus and dilatation of the pupil of the right eye. The pupil did not react to light, and the vision of both eyes was very defective. Ophthalmoscopic examination revealed nothing abnormal in the fundus. The family history was not good. The mother had never been a robust woman. When a girl she had had a good deal of trouble with strumous cervical glands, and later had developed symptoms of incipient phthisis, which, however, cleared up under treatment. For this child bromide of calcium was prescribed, and he was again brought up on December 21. He had then much improved. There was now no strabismus and he could walk much better. On January 4, 1895, there was still some difficulty in walking, but his vision was much improved and in other respects he seemed quite well. The boy did not come again, but Dr. Craig subsequently saw him when visiting his parents, and he was then quite recovered.

In this case, some gross lesion—very possibly a formation of strumous origin—was evidently present, giving rise to incipient paresis and failure of vision. Encouraged by the successful treatment of this and one or two other cases in tuberculous subjects where organic changes had actually occurred, I have used calcium bromide in the treatment of

two cases of tuberculous meningitis. They both ended fatally; but I am of opinion that in the case of each patient some alleviation of the distressing symptoms present in this disease was obtained. One of these cases presents some points of interest:

Two children of the same family had previously died of tuberculous peritonitis. This child, when aged four and a half years, was attacked by head symptoms attended by a varying temperature, some days almost normal and on others running up to  $102^{\circ}$  or  $103^{\circ}$ . After a fortnight's illness the boy recovered, calcium bromide being given throughout in alternation at different times with gelsemium, belladonna, and helleborus. I had some suspicion on this occasion that the mischief was tuberculous in origin, but for a time all went well. Six months later, however, similar symptoms recurred; a fairly typical attack of tuberculous meningitis supervened, with a fatal result at the end of three weeks from the commencement of the illness. Though calcium bromide was again exhibited, it failed to arrest the progress of the disease to any appreciable extent.

I think I have now enumerated the main conditions in which I have found calcium bromide of value. With regard to the question of dose, Dr. Hale seems, as a rule, to have depended on one to ten grain doses of the crude salt, and in the milder cases of erethism to have used the 1x or 3x trituration. Personally I have occasionally made use of the first centesimal dilution, but I have been more satisfied with, and have, as a rule, prescribed, an aqueous solution of the drug in the proportion of 1 to 5. It is with this solution—in drop doses, or fractions of a drop—that the majority of my calcium bromide cases have been treated.

## A REVIEW OF TWENTY-FIVE ABDOMINAL SECTIONS.\*

BY SHIRLEY R. SNOW, M. D.

**S**HOULD I enter too minutely into detail in reporting the following cases, I beg your indulgence on the grounds assumed by an orator, somewhat prominent of late, that it will be more valuable to read than pleasing to hear.

With the exception of four cases the operations were performed within the past eighteen months, at the Rochester Homeopathic Hospital, where the care received materially aided in the recovery of the patients.

The twenty-five operations consisted of the following:

Umbilical hernia, . . . . .	2
Ventral fixation of uterus, . . . . .	4
Removal of ovaries and tubes, . . . . .	11
Removal of uterus and appendages, . . . . .	8

Each case made a good recovery, differing from the others only in the benefit derived.

Passing over the umbilical hernia cases at present, we will first consider the ventral fixation of the uterus; two of these are not devoid of interest. Miss C. H., aged thirty-two years, came under my care May 21, 1895. Eight weeks previous she had undergone an operation to relieve the symptoms arising from retroversion; at that time the abdomen being opened the uterus was found to be enlarged resembling a pregnancy of three months, so much so that the operation was abandoned and wound closed. The following week menstruation began; the patient was closely watched. No fetus was expelled, but the uterus diminished in size. The patient was kept under observation; at the next menstrual period the uterus enlarged again and went through the same course as before. One week before the time for the next period I opened the abdomen and found

\* Read before the State Homeo. Society.

the uterus retroverted about seven inches in length, giving the appearance of a myo-fibroma. It was brought forward and retained by two silkworm gut sutures. After the operation the uterus returned to its normal size and did not become engorged again. The patient is entirely relieved of her former trouble. Had not the previous history of the case been known it would have been impossible at the time of operation to differentiate between pregnancy, fibroid, or simple enlargement due to engorgement.

Mrs. C., aged twenty-seven years, dressmaker, gave the following history: Married three years, no children, menstruated at thirteen, has been regular, but has suffered from dysmenorrhea, which has gradually increased in severity. Within past three years patient has suffered from backache most of the time; for one week before the period she has been unable to do much work, is confined to her bed five days during the period, and not able to work for two days after. That is, for two weeks of each month patient was useless. She had received local treatment for several months from one of our prominent physicians, who had endeavored to support the uterus with a pessary, but no relief was obtained. Upon examination the uterus was found retroverted and firmly adherent to the pelvic floor. The ovaries could be mapped out, but were not oversensitive. At the time of operation, June 25, 1896, I found the uterus bound back, ovaries partly cystic and bound to the tubes by adhesions, the tubes slightly inflamed. As the patient was anxious to become a mother, I had previously advised against removal of the ovaries, though they were slightly diseased. The adhesions were broken up and the uterus anchored to the abdominal wall. Four days after the operation patient was unwell and suffered considerable pain. At the next period patient was in bed two days; at the third period she was uncomfortable for two hours. She has had no backache since the operation, and her only complaint is that she is becoming too fleshy.

I shall watch with interest the behavior of the ovaries. While much may be justly said against so-called unnecessary operations, such cases as this make it a grave question to what extent we are justified in using local treatment when we have little chance of success. Are we not as culpable as the operative fanatic?

The other two cases were for retroversion, and both were cured by the operation.

For the sake of convenience let us consider the remaining cases under three heads:

- 1st. Removal of one ovary and tube.
- 2d. Removal of both ovaries and tubes.
- 3d. Removal of uterus and appendages.

1. Miss A. L., aged twenty-three years, came under my care April 10, 1894. She had suffered from dysmenorrhea for six years. One year ago patient was confined to her bed by peritonitis, since that time the pain at the menstrual period gradually increased; it being referred chiefly to the left side and was generally accompanied by irritation of the bladder. At the time of my first visit she complained of intense pain over the abdomen, exquisite tenderness over left ovarian region, frequent and painful urination, bowels constipated. Temperature normal. As the condition did not yield to remedies she consented to an examination under anæsthesia, with operation if necessary. Under the anæsthetic it was possible to distinguish an enlarged ovary on the left side. The abdomen was opened, the diagnosis verified, and the ovary and congested tube removed. The right ovary, being apparently sound, was not disturbed. The patient was discharged from the hospital at the end of four weeks. Her condition improved, and she left the city in good health. Six months later she began to be troubled with the right side, and I have since learned the right ovary underwent cystic degeneration.

Mrs. I. G., aged twenty-five years, mother of two children, menstruated first at fourteen years, had been irregular.

Menstruation was painful and at times profuse. She had received local treatment without benefit, and was unable to work. She entered the hospital in May, 1895. Under anæsthesia the right ovary was found enlarged and was removed. The left ovary, apparently healthy, remained. Eight months later the patient applied at the hospital again for help, and it was found that the remaining ovary had become cystic. The third case was similar to the above case, except that in the time that has now elapsed, some ten months, there has been no disturbance from the remaining ovary.

The last case of this set was Mrs. M. D., aged twenty-four years, no children; entered the hospital April 20, 1896. Patient had suffered from dysmenorrhea, being confined to her bed at the menstrual period. There was severe back-ache and she was rarely free from pain, the bowels were constipated. The patient was suffering from hysteria and melancholia, her great regret being that she was sterile. She had threatened suicide on this account. An examination revealed a retroverted uterus bound back by adhesions, and both ovaries enlarged. Although both ovaries were diseased it was considered best to leave one ovary, thus keeping up menstruation. The left ovary was removed and the cyst of the right evacuated. The uterus was anchored to the abdominal wall. During her recovery the hysterical condition increased so that at times it was necessary to administer narcotics. At the end of four weeks she was up and around; her mental condition began to improve so that she was allowed to go home, but she went back to her former condition, the mental symptoms increased, and it became necessary to remove her to the State Hospital, where, in an unguarded moment, she carried out her threat of suicide.

The second set of cases gives a more serious condition:

Miss N. M., aged sixteen, came under my care March 2, 1895. At the time of my first visit I found her in a cata-



leptic condition, from which it was impossible to arouse her. She had worked at a factory in the morning and had fainted away. She was brought home and remained in a comatose state about three hours. The following history was learned: Six months previous she had been unwell for the first and only time. At that time she received a fall and several splinters of wood were driven into the perineum. They were removed, although some set up suppuration. At the time for each succeeding sickness she had fainting spells and would have to stop work, but there had been no more flow. At this time the abdomen was sensitive, especially over the left side. The patient remained in bed three weeks, but did not improve. She then consented to go to the hospital, where I opened the abdomen and found both ovaries cystic and removed them. The girl made a good recovery. During her stay in the hospital she had one cataleptic seizure, brought on by seeing another patient in the same condition. Since leaving the hospital she has gradually gained so that she is cured of her trouble.

Mrs. E. C., aged thirty-eight years, entered the hospital April 21, 1895, having received treatment at different places for ovarian disease. A few days before she had been told, at one of our hospitals, that her trouble was too serious to permit an operation, but she wished relief and preferred to take the risk of an operation. Upon opening the abdomen a mass of adhesions was met, the omentum being bound down to the tubes. These adhesions were divided, and I dissected out what proved to be a degenerated ovary and cyst from a bed of adhesions on the left side. A similar condition was found upon the right side; running down back of this mass was a body resembling a large ureter, but upon close examination it proved to be an elongated appendix vermiformis. The entire mass was removed, leaving the uterus. A glass tube was left in the abdomen for twenty-four hours and then removed.

The next day I opened another abdomen and found

practically the same condition, excepting the appendix. This case received the same treatment. The two cases occupied adjacent beds in the ward, and it seemed as though one was stimulated by the other to see which could make the more rapid recovery. At the end of six weeks they both left the hospital. One is able to do a hard day's work, while the other has no further trouble from any pelvic disease.

Another case of this class was that of a girl, aged nineteen years, who entered the hospital as a possible case of typhoid fever. It was soon discovered that such was not the case, and she was transferred to the surgical side. Upon examination without an anæsthetic it was impossible to map out any of the pelvic organs, as the abdomen was extremely tense. Under an anæsthetic about the same sensation was given to the hand. Upon opening the abdomen the cause of the trouble was seen to be inflammatory tissue binding down the intestines and omentum to a mass in the pelvis. Upon dissection both broad ligaments were found to contain a large hematocele and it was nearly impossible to distinguish the degenerated ovarian tissue from the inflamed mass. In dissecting this out a piece about one and one-quarter inch in diameter was left on the small intestine, but was cleansed as much as possible. The uterus did not appear large. Since the operation the girl has gained some thirty pounds and is well, with the exception at the time for the menses she has flowed excessively for six or seven days. This has been controlled in part by remedies, but at times has presented a serious condition; during the last three months she has improved so that at the past period she flowed only two days. In connection with this I wish to refer to one of the cases of umbilical hernia. The patient, a woman thirty-nine years old, had, eighteen months previous, both ovaries removed. She had been unwell each month since and flowed to such an extent that it prostrated her. At the second operation the uterus was

found small, consequently it was not removed. Two other cases have come under my observation during the past year where a double ovariectomy was performed and yet the monthly flow continued, and in each case a more profuse flow than normal; so that I am led to believe that in such cases it were better to remove the uterus at the time of operation, if the condition of the patient would allow it.

The two remaining cases of double ovariectomy were for cystic ovaries and pyosalpinx. These were cured by the operations.

In three of the operations for the removal of the uterus and appendages the entrance to the abdomen was made through the vault of the vagina alone, while the remaining five were by the combined method known as the abdomino-vaginal operation.

In non-complicated cases free from adhesions, where the uterus is not large and the disease is more prominent in the cervix, the vaginal operation offers the quicker recovery. Even here it is a temptation to go through the abdominal wall to avoid a possible hemorrhage. On the other hand, where the uterus is large and there are adhesions, the diseased tissue filling the pelvis making the incision through the abdominal wall imperative, we save time and trouble by making an incision around the cervix in addition. It is easier to dissect the bladder from the uterus and saves time at the end of the operation, where otherwise we should have to do the dissecting deep down in the pelvis.

Of the three vaginal cases two were for epithelioma of the cervix—in one case the uterus and both cystic ovaries were removed, while, in the second, one ovary was left. The third case gave the following history:

Mrs. W., aged twenty-seven, had given birth to three children, all three dying at an age less than two years of syphilis inherited from the father. The patient suffered from back-ache, was confined to her bed three or four days at each menstrual period, and was unable to attend to her work;

there was an excoriating leucorrhœa. Upon examination there was found a rectocele, a partially prolapsed uterus, a stellate lacerated cervix, uterus elongated, ovaries enlarged and partially cystic ; also an umbilical hernia. Considering the history of the children and the above condition, I removed the uterus and ovaries and then repaired the hernia. The patient left the hospital in four weeks and has been well for over a year.

The five cases upon which I used the abdomino-vaginal method were more complicated.

Mrs. E. F. I was called to see May 11, 1896. One year previous she was operated upon in a neighboring city and was told that the left ovary was removed. She had not been well since the operation. She had been confined to her bed for two weeks with peritonitis. Any motion caused pain. The abdomen was tense and extremely sensitive, temp. 103°, pulse 130. Her condition being considered critical the ambulance was summoned and she was removed to the hospital, an anæsthetic was administered, and an aspirating needle was passed into the mass from the top of the vagina. On the right side pus was found ; on the left side the exploring needle brought out a straw-colored liquid. An incision was made in the posterior cul-de-sac and a pus cavity evacuated, but it was evident that there was further trouble. The patient was placed in laparotomy position and abdomen opened. There was fluid free in the abdominal cavity and a network of adhesions. After a difficult dissection I found a degenerated ovary and pus tube on the right side. On the left side was the ovary that had "been removed," and a number of hydatiform cysts as large as hen's eggs. The tube was inflamed, the uterus soft. The entire mass was removed, a speculum was passed into the vagina, and the pelvic cavity flushed with peroxide of hydrogen one to six ; the débris flowing out through the vagina. The cavity was packed with iodoform gauze, the end being left in the vagina, thus securing per-

fect drainage; the abdominal incision closed. The packing was removed on the third day and another piece placed in the wound. At the end of the sixth week the patient left the hospital cured. The second case was a fibroid growth of the uterus about eight inches in length, this was removed. The anterior and posterior flaps of the peritoneum were brought together and gauze drainage left in the vagina. The third case was similar to the second, with the complication of a pyosalpinx of the left tube bound down under the tumor. Case four was an enlarged uterus with double pyosalpinx. The last case was a double pyosalpinx, both ovaries were large and cystic, the uterus soft and cervix lacerated.

These cases were treated as the first, and each one left the hospital cured.

In conclusion it would appear:

1. That little advantage is obtained from the removal of one ovary. As Tait teaches, when one is removed the other should be taken; thus saving annoyance and danger of a second operation.

2. That each operation should be thorough and all diseased tissue removed. For this purpose the consent of the patient should be obtained, before the operation, to do whatever is necessary.

3. That when both ovaries are removed it is better in most cases to remove the uterus at the same time, if the condition of the patient will allow it. I recognize that opposition will be raised to this on the ground that the pelvic floor is weakened, thereby favoring hernia. It is probable that too early coitus is responsible for the hernia.

4. That in removal of the uterus through abdominal wall, great advantage is derived from an incision through the vagina.

5. That in estimating the benefit derived from operation it is necessary to allow sufficient time to elapse for the patient to regain her strength.

## PRACTICAL OBSTETRICS.

BY E. N. LEAKE, A. M., M. D.

WHAT thoughtful physician has not been pained at the criminal tendency of the mothers of this age? What a large percentage of pregnant females are burdened, in both mind and heart, with thoughts of murder during the early months of gestation. The far-reaching results of this damning condition of things may be noticed in the ever increasing list of murderers, some of whom come from sources that seem most inimical. Obviously the cause must be, that the period of gestation and the act of parturition is pathological instead of physiological. I want to say, emphatically, that the suffering to which the average American woman is subject, after becoming *enciente*, which lasts through 180 long days more or less, terminating more often than not in a bloody ordeal of suffering, is not an inviting pathway to ask her to enter. Wise obstetricians have been teaching in the past the skillful manipulation of abnormal cases. Wiser ones of to-day are beginning to teach the way the most of this trouble can be prevented. To my mind, the best way is the high way of education. We have had handed down to us by the teachings of Paganism a system of education that has almost ignored the importance of self-knowledge. "Know thyself," the Greek motto inscribed in the temple of Delphi, would produce most beneficent results upon the human race if adopted as its motto. How significant that our lady graduates may be able to discourse upon all the noted characters of ancient and modern times, may have acquired a thorough knowledge of the laws that govern science, yet, if asked the name of the man who discovered the circulation of the vital fluid that mounts her cheeks to give them a bewitching significance, would look in blank despair. The way our children are crammed to a mental development at the expense of

the physical, too often is the cause of a crippled physical inheritance. Our children should be taught practical physiology and made conversant with every physiological function as well as hygiene. The time has come when the successful family physician must be an educator in righteousness and truth. He should have his eye upon the youth of his families, and the question of good as well as vicious habits can be brought to the notice of thoughtless mothers and careless fathers by an intelligent array of facts by the medical adviser. Heretofore it has been considered that the accoucheur was needed only at the end of ten lunar months, but we are learning from the new light that is dawning that from the first realization the mother has of her condition his skill is needed to avert dangers, allay suffering and anxiety, and with this added knowledge of the case to come with much greater security and confidence at the final hour.

So great is the importance of this care that the work can never be ideal, and we are false to our trust, unless it is insisted upon, and under these conditions only can the accoucheur produce the best results in all there is to offer in hygiene and medical treatment. We will then oftener find childbirth is a natural condition, being robbed of much of its terror, and we will be more than paid in lessened anxiety through the puerperal state, by having nature act her best. As we come more directly to the act of parturition, we want to suggest that this age is rampant with the operative spirit, which too often needlessly and unskillfully invades this field of nature's work. We must not disregard the ordinances of nature and from overambition display skill unfavorable to the future welfare of our patients. Who can compute the suffering that often follows in the wake of this line of procedure which makes material for the gynecologist. I do not disparage the skillful use of instruments, for such use never did any damage. But alas! every accoucheur is not skilled in the use of these tools, as is

evidenced by the fact that, more times than less, they are applied without the adequate knowledge of the position of the head.

Motherhood at best is the essence of sacrifice, and while there are burdens that must be borne, she should receive the benefits of careful prescribing, thoughtful attentions, and skillful manual assistance if necessary. To this end I have found chloroform and hot water to be indispensable in every case of dystocia. The former, used just enough to blunt the sensibilities, quiets the nerves, assists dilatation, and has for me converted a bed of agony into a natural case of labor with its intermitting pains and restful inter periods. Hot water I often use in the first stage and always as a post-partum injection, in dystocia, to wash out the womb, get rid of the débris, assist contractions, and complement rapid convalescence. I was not long in practice before I discovered a direct hindrance to the mechanism of labor, oftentimes, in the presence of that liquid forerunner of the *caput succedaneum*, called the bag of waters. If the amniotic membrane be strong and the fluid profuse it will often prevent the head from engaging in the superior strait. This I have often demonstrated by puncturing the membrane at an early stage and witnessing the immediate descent of the head. At the end of each contractive pain I usually slightly raise the head to let the fluid escape, for I believe it a mechanical impossibility to get the full benefit of the contractive force of the womb till it comes directly in contact with the body of the fœtus. The *bête noire* in my practice is a complete tear of the perineum. I consider it a very serious misfortune, not because it cannot be repaired, but because it cannot be made by repair just what it was before.

After the experience of delivering a child that weighed 17 pounds, and another that weighed 15½ pounds, in a primipara, I am not going to argue that the perineal body need never give way, but I don't believe a complete



tear will ever occur under my supervision again. While cases like the above demonstrate that the vulvar orifice must in some cases be enlarged, I propose to dictate the *modus operandi* of the procedure, and make the enlargement in a manner that can be much more easily repaired and be of far less inconvenience to the patient in answering the demands of the daily functions of the bowels. I have clearly demonstrated to myself the proper place, and the wonderful advantages in performing episeotomy in preference to a bad tear into or through the perineal body.

If it be highly necessary in surgical work to leave the wounds aseptic in order to obtain the best results, why is it not just as necessary to leave the womb aseptic after parturition.

To obtain the best results in the lying-in chamber we must leave the uterus, firstly, firmly contracted and retracted; secondly, perfectly empty and aseptic; thirdly, in good position to secure good drainage. It is safe for me to say if these three precepts could be exemplified in every case of labor, puerperal fever would never be known. But being finite in knowledge and accomplishment, we cannot always be sure of the results. Nevertheless our watchword should be no compromise with a septic uterus. Deficient contraction and retraction of the uterus allow oozing of blood and the accumulation of clots in the cavity which at best will result in a tedious and unsatisfactory convalescence and possibly invalidism, and the possibility of hemorrhage is at any time imminent. Intra-uterine injections of hot water and the proper kneading of the uterus will obviate this condition, and if followed by packing the uterine cavity with iodoform gauze will control the most serious hemorrhage.

If the womb is not empty and aseptic we will find retention of placental fragments or shreds of membrane which invite the bacteria of putrefaction and the development of ptomaines with absorptive fever; this is manifested by a rise of temperature, an abnormal lochia either in quantity

or character, or both, usually with marked soreness of the womb. These symptoms demand the prompt and thorough use of the blunt douche curette which will cause the horrible symptoms to vanish if applied before systemic involvement. I must say most emphatically that when putrefactive changes are going on within the uterine cavity that the homeopath has something else to do than prescribe the indicated internal remedy, I care not what is its potential. Then if the womb is left displaced you have backache, intermittent flow of lochia, and a long train of symptoms that will clear up by rectifying the cause.

The successful accoucheur is the man or woman who knows what are the necessary requirements from a physiological and aseptic standpoint, and then bends his or her energies to make everything come up to the requirements. I am constrained to admit that the distinctive characteristics of our school of medicine develop a weakness, in that we are too often lead to believe the *sine qua non* is the indicated internal remedy, and somehow are lead to feel that we have done all we could do if we exhibited the same; while in fact the human body oftentimes, in some of her labyrinthian tracts, develops putrefactive fountains of poison upon which the indicated internal remedy is as powerless to produce an effect as water on a duck's back.

I believe the prerequisite on the part of the accoucheur is an early recognition of the size of the pelvis and the presentation of the head; to this end a small hand and sufficient tactus eruditus in the ends of the fingers are wonderful advantages. This early knowledge is especially needful when we have a presentation other than the first and second positions of the head. But we must not forget that the majority of occipito-posterior positions convert themselves into the anterior. When the head is well flexed, as the occiput descends to the pelvic floor, rotation then voluntarily occurs and delivery is made easy; the minority of cases do not rotate, and in the language of another I will say there is no situation in obstetrics that makes greater demands

upon the strength and skill of an operator than the extraction of an impacted occipito-posterior position of the head, the cause of the impaction obviously being the fact that the short end of the lever (the occiput) is caught upon some part of the brim; the long end of the lever (the forehead) is driven in the canal, the head becomes extended, the occiput turns backward into the hollow of the sacrum, and descent is impossible.

The first method offered to obviate this condition is called the prophylactic posture. The mother is placed in the knee chest position, which allows the fetus to sag away from the brim of the pelvis and turn on its axis, because the tendency is for the back of the fetus to occupy the anterior wall of the womb, then when the occiput rotates anteriorly, the membranes are ruptured and birth occurs *secundem artem*.

If posture is useless, anæsthetize, insert the left hand far enough into the uterus to firmly grasp the head and turn the occiput forward, with the right hand on the abdomen, turn the anterior shoulder at the same time in the same direction. This method is quite successful with the membranes unruptured and oftentimes succeeds when the uterus is firmly contracted and the waters have escaped. If the head does not seem inclined to stay in position long enough to engage in the superior strait, slip on the long instruments, and use downward traction with each pain till it does engage. Podalic version should be chosen rather than high forceps, by an inexperienced operator. However, it is better indicated in a multipara than a primipara. The delivery of a living child under these circumstances depends upon the expedite delivery of the after-coming shoulders and head, which is complemented by delivering the perineal shoulder first and then applying the forceps to the head within the Walther posture, which increases the conjugate from  $\frac{1}{4}$  to  $\frac{3}{4}$  of an inch. In this attitude the thighs are extended over the edge of the bed as far as possible and traction made downward.

In the use of instruments two factors are to be considered: an instrument adapted to the requirements and a perfect familiarity of the same by the operator. In a high forceps delivery a strong inflexible instrument, like the Simpson, Elliott, or best of all for my use, Burdicke, for compression as well as traction is required. The axis traction forceps or rods are well adapted to some high applications where backward as well as downward traction is necessary. With the mother on her side this can be perfectly accomplished. Reynolds advocates the use of the reversed forceps. It is an application of the ancient principle, that the tips of the blades should always be directed toward the leading point of the presenting part, and is used to produce flexion only. When the occiput is driven down into the hollow of the sacrum, the forehead in front of the pubes, the forceps, reversed, are applied to occiput and flexion produced till the occiput leads the way, I prefer my small hand with the assistance of the vectis, and have been able in soft pliable heads to bring the occiput down first, but in hard unyielding heads I have more often been able to convert them into face presentations. Barnes, a leading representative of the more conservative school, says, Wait two or three hours after the head has engaged and the os wide open for the head to rotate naturally. If it does not do so, apply forceps and make steady traction, taking care not to hinder rotation but to leave the turns to nature.

Grandin, a leader in the operative school, says, Delay forceps as long as possible; when, if the mother shows signs of exhaustion or the fetal heart becomes feeble, there is no other resort but forceps, apply the blades on either side of the head, loosen them often to admit of possible rotation. You notice Grandin says apply forceps to the head, which is the mooted question. The American and English operators apply them to the sides of the pelvis, the French to the sides of the head. Both ways have their disadvantages. If the forceps are applied to the sides of the pelvis and

continuous traction made you will prevent rotation. While if they are applied to the sides of the head, the tendency is to extend the head, unless you are sure you are making traction on the occiput, and that is another way of saying you prevent rotation. I don't believe it possible to apply forceps to a large head in a small pelvis, regardless of the walls of the pelvis as land marks, without doing damage to the soft parts of the pelvis, especially when you permit the instruments to accompany the head while rotating. The best results are obtained by removing the instruments once in a while, and allow Nature to have her own way.

In Dubois' famous experiment upon a recently delivered dead woman, he placed a fetus in the right occipito-posterior position, and when suitable pressure was produced, the fetus descended with the head flexed (*i. e.*, the occiput leading), and when it came down to the floor of the pelvis it rotated anteriorly every time till the soft parts became so stretched that they offered no resistance, then it rotated posteriorly. When a larger fetus was used it again rotated anteriorly. So you see three factors are necessary to accomplish the proper rotation; (1) marked flexion, (2) good strong labor pains, (3) firm resistance of the soft parts. In practice I have demonstrated many times that when the pelvic floor is perfect, firm, and resisting as we find in primiparæ that the head will eventually and quickly rotate when there was seemingly no progress for a considerable time. But if attending a multipara of frequent and rapid labors, especially if she have a lacerated perineum and the pains are weak as they are apt to be, I am much more fearful of rotation posteriorly and do not wait before rendering assistance instrumentally or otherwise as previously indicated.

To become a skillful obstetrician requires a certain refinement of operative technique and skill which those only exceptionally gifted with the mechanical sense possess, and which is more difficult to acquire than anything mechanical connected with the practice of medicine.

## SUMMER DISEASES OF CHILDREN AND THE REMEDIES.

By C. G. WILSON, M. D.

**N**CESSARILY, summer diseases are those that result directly or indirectly from too much heat and light. Children have a specially favored place in the heart of the doctor, for they are so helpless, pitifully so. They cannot, literally, tell how bad they feel. When they can, they have but two complaints, a headache—frontal, and a stomach-ache.

There are only two preventives for these diseases. One is only partial, that is, to keep the child in health up to the beginning of hot weather. Have them avoid as far as possible all contagious diseases. Many people care little if their children have measles or whooping-cough because they believe children must and should have them, and feel especially glad if they have them in the spring. Such people need to be taught to keep the children from all such diseases until they are at least four years old, and in health, as they are then more amenable to treatment and nursing. The sure preventive is to live where there are no summers, or if any, very cool ones, with cold nights. Both of these conditions, however, are ideal, and not often practicable.

Anywhere in this State we can secure plenty of fresh air, shade, quiet, and sensible dress for the little ones. The need of fresh air, and constant renewal of air, is shown in the benefit derived by the tenement children from the Fresh Air Fund trips of two weeks to the country or at the seashore. Maybe the infinitesimal doses of nat. mur. or calc. ph. in the air do much of the good, but the child is certainly renewed and has a new lease of life.

Shade is nearly as necessary as fresh air. The infant is a very sensitive being. Tears and laughter are frequently commingled. The child is but one remove from the protoplasmic state, and the least harsh treatment ruins it.

When the nervous centers are depressed by heat all the nutritive functions of the body are suspended. Just as the Chinese criminal is detected by the test of chewing rice. He is so frightened he has no secretion of saliva and the rice is spit out dry. "The heart bowed down by weight of woe" has no appetite, and if food is forced no digestion. The food sticks in the throat or remains a load in the stomach. Often there are no tears. So with the child. Its food must be lessened as it fails in health. Sometimes, as in cholera infantum, all food must be withheld for days altogether, the doctor being governed, of course, by the ability of the child to digest milk from the appearance of the vomit and evacuations. The child must be lightly dressed. The hardest thing to impress upon well-to-do people is the fact that they overdress their babies. It is not too much to say, if the babies of this city out in their perambulators are examined to-day there will be found the woolen shirt, flannel belly band, flannel skirt, perhaps a flannel pinning blanket, certainly a cotton skirt and dress, a knitted sacque and a beautiful crocheted baby-spread over all; while their mothers are sitting in the breeze clothed in the thinnest of muslins with a fan. The child is much more sensitive to extremes of cold and heat than adults. Experience teaches the foolishness and harm of the flannel binder. It is of no earthly account after the third day of infant life when the cord, having been cut half inch above the ligature and covered with antiseptic gauze, should have healed without odor or sign of inflammation. The band is usually twisted, or under the arms, or soiled by the discharges. What the child needs is a light, armless, and low neck gauze or nuns-veiling shirt coming to and pinned down to the diaper. Then a cotton skirt and slip. In the middle of a hot day the skirt may be removed, and, if no draught, the dress also. In mornings and evenings when it is cool a jacket or cape may be slipped on for a short time. The shirt should cover the abdomen day and night to avoid too rapid chilling of the intestines. The child should not be

put to bed in unaired rooms or rooms which have not been cooled by the evening breeze. If the child continues to decline, the mountains are the last hope.

When outdoors or near a window the child should not be permitted to be without a shade between its eyes and the glaring sky. When you realize how light affects a nervous and depressed person, and also how trying it is for anyone to lie on the ground and look up into the sky, you can easily see the necessity of having the parasol of the baby's carriage a neutral color, and also have it down so close to the child's face that it cannot be affected by the light from above. Green wire screens in windows and doors not only modify the light but keep out flies and mosquitos. They also obviate the necessity of that warm but otherwise comfortable mosquito bar. Fanning the child has to be resorted to, also sponging arms and legs with tepid water occasionally in serious cases.

The child should have plenty of water, cool water, every hour during the day. If it will not drink from a cup, fill its nursing bottle. Add the same amount of sugar as in its milk, and if necessary warm the water a little. Often water is the only prescription necessary when called to a fretful, sleepless, struggling child in summer.

Quiet is the last thing to be mentioned in management of a child. Commotion, noise, fussing, and crying over the child are enough to make it sick. Let it rest as long as possible. It should sleep alone. It will be cooler and less apt to be disturbed.

Never let the baby nurse the mother from 9 P. M. till 5 A. M. after it is over three months old, in summer. If it cries and insists on something, have the bottle of warm sweetened water at hand. It satisfies the child and does not derange the stomach. Do not let the baby nurse oftener than every two hours after it is three months old. If it frets for something—the bottle of water again. When its milk disagrees, as shown by vomiting curds, etc., dilute the milk with an equal quantity of water. If it still disagrees,



dilute still more. If still curds form, add a grain of salt to each feeding. Also a few drops of bovine. That alone often corrects digestion. As to baby foods it is "cut and try." Commence at A and go through them all to Z, or until one is found to agree. By the time you have tried the last one the baby will not need food of any description probably.

Sterilizing milk has been a great boon to children. I always dilute milk one-fourth to one-half even with healthy children when it is sterilized. My only reason is experience. It has always been more easily digested, no matter what the parents say about starvation. What the baby assimilates is what counts, not necessarily what it eats. When a child is a year old it is well to accustom it to table food if in winter or spring. Such children seem to have a better hold on life than entirely milk-fed babies.

The drug treatment is well shown in Guernsey and Bell. Teste also has some admirable ideas, but one could scarcely call them homeopathic so much as Teste-pathic, for he gives no reason for the use of remedies except his experience. From what has been said it is expected that remedies acting mainly on the nutritive and nervous system will be most called for.

*Æthusa.* Vomiting curdled milk immediately after nursing and lumps of undigested milk in evacuations.

*Cham.* Hot sour actions. Fretful, wants to be held.

*Cina.* More fretful, nothing pleases. Urine thickens on standing, actions from bowels very offensive.

*Kreas., Psor., and Sulf.*—Also noted for offensive actions.

*Nat. mur.*—An excellent nutritive remedy.

*Lyc. and Sulf.*—When excoriations exist, many boils, thin neck and body.

By the way, if an infant begins to have blood boils or small abscesses before close of summer you must do your work well to keep ahead of the undertaker.

When restlessness, sleeplessness, rubbing head, moaning, crying in sleep, fretfulness, etc., manifest themselves, showing irritation of the brain, mag. phos. 3x every hour or two has brought about speedy and permanent relief.

## MARASMUS—MALNUTRITION.

BY WM. E. LEONARD, M. D.

I HAVE purposely chosen this unscientific heading as including those causes that lead to wasting in infancy, hoping thereby to do something toward lessening the carelessness of those who still give "Marasmus" as the cause of death. In every city and health office in this country each year, death certificates with this cause are to be found, which to the thinking practitioner mean no more than does "Heart failure" as accounting for the decease of an adult. No careful physician will be satisfied with such a diagnosis.

The following include all, or nearly all, of the conditions leading up to wasting, given, as far as possible, in the order of their frequency. The paper is intended to be simply ætiological and suggestive rather than therapeutical.

I. *Inanition—Starvation.*—This cause for simple general atrophy or wasting in infants is the most common according to statistics. But it must be remembered that statistics, especially the English, have been compiled from the great cities and institutions where large numbers of children from the poorest classes are congregated, and that in private practice cases of that kind should not be frequent. Nor is such a diagnosis to be made without the careful exclusion of all other causes to be hereinafter mentioned.

A child born of healthy parents and nursed by its mother from birth does not readily take on this condition. But when, as often happens, the mother either has no milk or will not be troubled by nursing the infant, or her milk is of inferior quality from her being under-fed or diseased, artificial food becomes a necessity and, by its improper use, the foundation may be laid for literal starvation of the infant. No hard and fast rule can be laid down for the government of American women whose first babies seem to starve on the mother's milk, for the second may find plenty of good milk. Nursing is always the desirable thing if it can be

brought about. If there is only a partial supply it is better to supplement that with an artificial food than to wean the child—a rule I've only of late years learned to respect, having always dreaded giving two foods at the same time. Of course syphilis and tuberculosis in the mother calls for weaning at once. If by analysis the mother's milk is found lacking in certain constituents, no fixed diet, however well and carefully prepared, will correct it. Be it known also that chemical analysis often fails to show how the milk does not agree. If then a brief trial of some such true galactagogue as puls. or phytol. in homeopathic potency fails to change, weaning should promptly follow. In practice among the poor of great cities it is very possible for the milk or other food to be entirely insufficient from its dilution, but more often it causes wasting and starvation because it is not properly cooked or predigested, and is therefore absolutely non-assimilable.

But occasionally the child of a well-to-do parent is ignorantly or carelessly fed, and thus brought into a marasmic state.

The physician is not always as quick as he might be to detect the early symptoms of inanition. Fretfulness and loss of weight are the chief symptoms. The normal increase of one-third in the first month, one-half in six months, and treble in a year is entirely wanting, and its absence is shown in the peaked and anxious look, a depressed anterior fontanel, constant crying and sucking of the fingers and anything within reach, and a dry wrinkled skin. The end may creep on gradually without any further symptoms, but more often the progressive anæmia is accompanied by indigestion, vomiting, and diarrhea. The tongue is furred, vomiting occurs after each meal, the ejecta being sour and containing much mucus, and there is evidence in the face of abdominal pain, with distension and tenderness. The appetite may fail altogether, with a subnormal temperature and the appearance of thrush, or the hunger will be ravenous with apparent relief of the fermentation and flatus from the

undigested food by frequent feeding. In such cases the wiseacre old woman commonly appears and boldly states "that child is starving and must be fed more frequently," even to one-half hourly, as I have known to be done to a dying child.

If the food be too starchy, obstinate constipation instead of diarrhea will be present.

The prognosis of such cases is generally hopeful if vomiting and diarrhea is not gone on too long, for resting the stomach upon water for a day or two, or giving only diluted milk or the white of eggs in water, will often start anew the machinery of assimilation with successful results. Change of environment, *i. e.*, better sunlight and air, is always essential in the treatment of such cases among the very poor, and hence the hospital is often their salvation.

II. *Tuberculosis*.—Since the discovery of Koch's bacillus, this disease has been known as specific and infectious, characterized by the presence of miliary nodules or more or less aggregated masses of so-called "tubercle" and containing the bacillus. Yet without an absolute histological test it is also true that the bacillus may be absent in cases offering undoubted clinical and anatomical evidence of tuberculosis. Bearing in mind this bacteriological weakness of evidence in all instances, it should be remembered that wasting is very often due to this disease in young children.

In the recent study of statistics the fact is also made clear that tuberculosis is not necessarily an inherited condition. In an analysis of English hospital records by Dr. Sturges, quoted in Donkin, "Med. Diseases of Children," p. 145, of 204 tuberculous deaths, 107 showed trustworthy family records of health, 44 had 1 phthisical parent, and 1 only both phthisical parents.

It follows then that the tuberculosis bacillus of Koch gains free entrance into the systems of children without parental or inherited influence. Such ways are thus far proven to be (1) the milk, which should therefore always be sterilized, (2) infection by phthisical sputa, and (3) general

unhygienic surroundings. Probably certain diseases in some way bring out the latent tendency toward or actually prepare the soil for tuberculosis, such as measles, whooping-cough,—undoubted instances of which I have observed,—broncho-pneumonia, enteric fever, and epidemic influenza or la grippe.

Having in mind these possible modes of infection, the following train of insidious symptoms should lead one to prophesy tuberculosis: loss of appetite, wasting, anæmia, some œdema of the feet, remittent pyrexia (very slight at first), and general irritability. Many of the conditions of malnutrition detailed under inanition may accompany, and the entire diagnosis be doubtful until the disease localizes in the chest, abdomen, or head, or a *post-mortem* makes the whole matter clear.

The distinctive points are the pyrexia and œdema. Excellent old school authorities do not make a necessarily grave prognosis in the beginning of such cases, even in the meningeal form, much less should the homeopathist.

III. *Syphilis*.—The mother's history of repeated abortions of macerated fetuses should always make the practitioner suspicious of the child under consideration. In this disease also wasting is an early and pre-eminent symptom. The diagnosis is easily confirmed when, with the weazened, monkey-like appearance of the infant a few days or weeks after birth, there is wakefulness at night with weakly crying, nasal snuffling, and generally coryza and a discolored and inelastic skin. If these signs are not sufficient the inner surfaces of the nates and thighs show patches of erythema which soon take on a shiny or coppery appearance, or the skin of the palms and soles becomes red and freely desquamates.

The irritation of the discharges may cause similar appearances, although a marked erythema spreading down the thighs is probably syphilitic. Papular rashes anywhere, and especially those about the mouth and anus, often fissured and ulcerated, all become conclusive signs.

Later in life the slow evolution of the teeth and their saw edges, together with the poor development of the long bones, may indicate this disease as well as also rickets, which it should be remembered may be readily engrafted on or follow along with syphilis.

Nervous or brain lesions also confirm the diagnosis later.

IV. *Rickets*.—While the well-known osteal changes, especially along the sternum and at the epiphysial ends of the long bones, of this affection generally renders a diagnosis certain, the profuse sweating, slight pyrexia and digestive disturbances, with wasting, after the osteal changes are well under way, are confirmatory, and in their entirety distinguish rickets from any other disease of malnutrition. Wasting is not so prominent and marked a symptom in this as in the other conditions mentioned, for the rickety child may retain its flesh and fat until a late stage, although never presenting the firmness of flesh and fiber that goes with perfect health.

Restlessness and irritability are present as in tuberculous infants, and also sometimes enlargement of the liver and spleen.

Here also when old school prognosis is good, the homeopathist, with his accurate knowledge of the various salts of lime, silica, sulphur, etc., ought never to lose courage.

V. The atrophic changes following enteric or other fevers are in themselves signs and causes of malnutrition, as for instance, phthisis and tuberculosis.

VI. Finally an undiscovered empyæmia, without marked symptoms of pyrexia, is a rare cause of wasting in infants.

In conclusion then, the term marasmus has no place in medicine except as defining the first cause of wasting mentioned, viz., starvation or malnutrition. The other causes mentioned should be carefully excluded and with none, except perhaps syphilis, should the prognosis be entirely unfavorable when proper conditions and care are obtainable.

## THE CLINICAL HISTORY OF OVARIAN GROWTHS.\*

BY GEORGE BURFORD, M. D.

**I**N this article I intend to deal solely with certain forms of ovarian tumor, and to dwell mostly on my own clinical experiences, and these not of the kind ordinary and familiar to all, but as touching certain clinical facts nearly as frequent, and just as important, but of which less is generally known.

First, I wish to instance the infective powers of some ovarian tumors, conditional on their encapsulating membranes being infiltrated or ruptured, and thus allowing the dissemination of ovarian tumor contents in the peritoneal cavity.

So long as the capsule of an ovarian tumor remains normal and intact, so long it presents an effective barrier to the transplantation of tumor contents into the general peritoneal cavity. *Sowing the peritoneum* is the suggestive phrase used when perforation or rupture spreads the contents of a pathological new growth broadcast through the great serous sac. The leakage naturally primarily affects the contiguous serous area, and when the cellular elements of this leakage are capable of independent growth, they repeat on the fruitful surface of the peritoneum the rapid growth previously confined to the interior of the cyst.

*Colloid Ovarian Tumors.*—Ten years ago I assisted at an operation for the removal of an ovarian tumor, and it caused me much reflection. The primary lesion was an ovarian cyst with colloid contents; the cyst wall had ruptured some time anterior to operation, and the contents had leaked into the peritoneal cavity. The colloid matter thus sown freely on peritoneal surfaces had caused actual colloid degeneration in scattered areas of the peritoneally-covered organs—e g., on the intestine there were to be seen small patches of colloid degeneration, thin and translucent, which

\*British Homeopathic Society.

the least rough handling would have ruptured. Disseminated colloid degeneration such as this it was, of course, impossible to remove, and the patient succumbed, a victim to the postponed operative removal, which, anterior to rupture, would have brought about a complete cure.

Again, in 1893, I saw with Dr. Hall a young girl, unmarried, who had recently developed considerable abdominal distension. The abdomen was filled with free fluid, and further, on vaginal examination, a soft floating mass was plainly made out lying to the left of the uterus. The patient was brought up to town for operation, and on re-examination the increasing abdominal distension entirely barred a renewed attempt to define the new growth. Being quite sure, however, of my former palpation, I opened the abdomen, evacuated a considerable quantity of free fluid, and then drew up from the pelvis a cyst containing colloid material, but so soft and doughy that the fingers in elevating it actually, and without effort, penetrated the viscous cystwall. The cyst was removed, and submitted to Mr. Johnstone for pathological report. So forbidding were the histological characters that he would not state that the growth was non-malignant, and therefore the prognosis as regards recurrence was doubtful. Although the irritation of the cyst had caused so much ascites, fortunately the neoplasm was removed ere the colloid contents had sown themselves in the peritoneal cavity. The patient made a good recovery, and remains now, three years after operation, with no recurrence.

In July of the present year my colleague sent to me a young girl in whom he had detected an abdominal growth. I saw the patient, agreed with his diagnosis, and arranged for operation. The physical characters of the growth were exceedingly puzzling, and led to a diversity of opinion among my colleagues. My own diagnosis, founded on the experience of other puzzling cases, was that of flaccid cyst. There was no free escape of fluid. On opening the abdo-



men, I found a cyst almost the counterpart of that in the last narrated case. The cyst walls were sodden with infiltration of colloid contents; the peritoneum could be rubbed off by very slight friction, and the viscous cyst mass here also was unable to withstand any pressure from the fingers. The girl made a good recovery.

I have selected these three cases as constituting an ascending series, indicating by their physical condition the transition from moderate, through pronounced, up to mortal participation of the cyst peritoneum and contiguous serous areas in the ovarian new growth. In the last case, the cyst peritoneum was infiltrated, but not sufficiently to cause ascitic effusion; in the previous instance, with the infiltration of cyst wall was ascitic effusion, but there was no actual rupture of cyst wall; while, in the first case, the free entry of the colloid material into the serous cavity, secondary to rupture of the cyst wall, had engendered a similar degeneration, here and there, of organs whose integrity was essential to life. Had this growth been removed anterior to rupture, in all human probability the results would have been similarly happy to those recorded in my own cases.

*Ovarian Papillomata.*—Let us now turn our attention to a somewhat different form of ovarian growth. A very interesting case of papillomatous tumor of the ovary was reported by Dr. Ord in August last. Dr. Ord well describes how papillary growths in the ovary had found their way, by rupture or perforation, from the ovarian tumor into the peritoneum, and there had run riot, so that after the ovarian cyst—their original site—had been removed, the local peritoneum was still studded with a similar growth, which ultimately led to death. In a note, referring to this case, I called attention to the remarkable clinical fact that after papilloma, primarily ovarian, had sown itself broadcast in the peritoneal cavity, sometimes abdominal section, removing the original ovarian focus, caused in some mysterious way the absorption and disappearance of all that growth

which had spread over the peritoneal surface. In many cases, however, no such result accrued; so that here we have the noteworthy fact that of two papillomatous cysts of the ovary, identical in origin, in mode of increase, in dissemination over the peritoneum by perforation of the cyst wall, one case will, after removal of the cyst, lose all the remaining peritoneal papilloma by absorption; while the other will do nothing of the kind, the transplanted peritoneal papilloma growing fast and furiously, after its primary site had been removed. Such a case I had under my care during this year. A young girl, of emaciated and pallid aspect, consulted me on account of a large and very painful abdominal swelling. There was also a marked febrile movement. Operation being done, a moderately sized ovarian cyst was removed, studded with papillary growths. These had already, by some mischance, found their way into the peritoneum, and become engrafted there; and the whole pelvis was thickly studded with papillary growths. I hoped that the removal of the cyst would have set going the absorption of the peritoneal growth; but this did not occur; and some two or three months after recovery from operation the patient succumbed to the rapid increase of the peritoneal affection. I emphatically state that, had this case come to me, and been operated on, before diffusion of the papillary parasitism, in all human probability that patient would have been now alive and well; instead of affording another mournful instance of that delay which is not merely dangerous, but actually fatal. Kali bichromicum was the remedy diligently taken with a view to aid absorption; but, in this case, time and the lesion were adverse.

*Solid Ovarian Tumors.*—The two forms of solid tumors, benignant and malignant, so closely simulate each other that only the most discriminating clinical history can, apart from microscopical aid, differentiate one from the other. In 1892 I saw, with Dr. Dyce Brown, a young lady suffering from ovarian tumor. It was of quite recent advent, and,

on removal, was found to have a pedicle so thick as to require extra-peritoneal treatment. The lady made an excellent recovery, and the growth has not recurred. In the same year I saw, with Dr. Goldsbrough, a young girl with a solid abdominal tumor, which dated apparently from a fall some two months previously. As this mass was evidently rapidly growing, it was removed by operation, being then of the size of an adult head. The pedicle was no thicker than an ordinary cedar pencil; but between the tumor surface and the abdominal wall some adhesions were found. The patient recovered; but, six or eight weeks after operation, recurrence took place in the neighborhood of the adhesions, and the patient, in a year's time, succumbed to the malign influence of sarcoma. I showed this specimen at the British Gynecological Society, and, in a discussion, one of the leading operators in England gave us the results of his very wide experience. He said that solid growth of the ovary in young girls under twenty was almost invariably sarcoma; that, although apparently completely removed by operation, the growth recurred so quickly as to give the operator the impression that all had not been removed. These points were well illustrated by my case; and I would again indicate that recurrence apparently occurred soonest where adhesions had provided a bridge for the translocation of sarcomatous elements. Sarcoma of the ovary is not, however, confined to the adolescent. In 1891 I saw, with Dr. Dyce Brown, a lady aged fifty in the throes of a furious outburst of peritonitis. A large abdominal tumor of recent and rapid growth was evidently the *fons et origo mali*; but for weeks the physical signs of peritonitis were so marked as to preclude any more exact estimation of the nature of the neoplasm. The convalescence was very peculiar in its sequence of symptoms. A gastric crisis was developed earliest, and took the form of constant and almost intractable vomiting. Arsenicum was the most potent remedy, and after a time the stomach ceased to markedly trouble.

The next crisis was respiratory. A dry, distressing cough, markedly aggravated at night, prevented sleep and destroyed appetite; and about every third night there would be an acute exacerbation. Codeia, in minute doses, was here of paramount service.

The most distressing crisis, however, was cardiac. A sense of great oppression in the chest, anxiety, restlessness, and inability to lie down were the main subjective features; and the patient's condition while battling with a seizure was pitiful to behold. Strychnine nit.  $\frac{1}{100}$  in the course of a few days effectually banished these unpleasant conditions. The physiological significance of these symptoms is obvious. They were originated in the three great areas of distribution of the vagus nerves, *i. e.*, the abdomen, the lungs, and the heart. The crises were respectively gastric, respiratory, and cardiac. Bearing in mind the free anastomosis of the abdominal sympathetic with the ramifications of the vagi, it is, I think, a fair interpretation that the peritoneal irritation of the abdominal sympathetic was reflexly discharged through the vagus nerves, and manifested as reflex vomiting, bronchial irritation, and cardiac interference, successively. In course of time the patient continuously improved in general health, and left her bed and her room. Concurrent, however, with the general betterment it was noticed that the abdominal girth was increasing; and, so soon as the general health would permit, abdominal section was advised and carried out. Greatly grieved were we to find that the neoplasm was of malignant character (I believe sarcomatous), imbedded in dense adhesions, and unremovable. To this incurable malady the patient eventually succumbed.

*Strangulated Cysts.*—Strangulated ovarian cysts supply the most interesting of the records of this class of growth. Their clinical phenomena were striking, the import of these is definite, and the clinical course is usually acute and brief. The first case of the kind on which I operated—in 1891—was a typical instance. The symptoms were those of intes-

tinal obstruction, biliary vomiting, complete absence of stool, much abdominal pain and distension, with pyrexia. The tongue was dry; sleep was broken and occasional. I removed a strangulated ovarian cyst, and the urgent symptoms immediately abated, the patient making a good recovery. A few months later I was called by Dr. Neild to see a puzzling case. The lady had been recently delivered of a child at term, and at that time a pelvic growth, of only quite moderate dimensions, was observed. Three months afterward, on making a sudden lurch, acute pain was experienced in the left side. Vomiting shortly afterward set in, and persisted for two or three days; there was also a moderate rise of temperature and pulse. But the most notable symptom was complete constipation, for nine consecutive days; and then, an enema being given, so marked a tendency to collapse ensued that operation was decided upon. The abdomen was now inordinately distended, the outline of coils of intestine being visible; and the percussion note was unusually tympanitic. Vaginal examination yielded no further information. Operation disclosed a large strangulated ovarian cyst, positively black in tint, which was removed, the patient making a very good recovery. In this, as in other similar cases, over and above the other acute symptoms attending the seizure, we have the crucial symptom of complete intestinal paresis. I have noticed this condition in all my cases, and, where sufficient time is given for its manifestation, I regard it as an invaluable clinical sign.

*Suppurating Cysts.*—Coming to suppurating ovarian cysts, in 1889 I saw, in consultation with Dr. Hall, a patient suffering from peritonitis, concurrent with an ovarian cyst. There was then no splendidly appointed hospital, equipped with all that the wit of man could devise, to transfer her to *instantly*: we had to plan ways and means for the necessary operative measures. She was transferred to the Surbiton Cottage Hospital, and I undertook to operate.

The case was that of a young girl, under medical treatment for some time with acute peritonitis, secondary to the growth of an ovarian cyst. The abdomen was opened, and such a *mêlée* of contents was exhibited as I have never seen before nor since. The abdominal cavity was like the interior of an abscess sac; layers of exudation material covered all the viscera; no intestines were to be seen, no peritoneal coat was visible. The cyst wall was rotten; pieces of it came away in the hand like wet brown paper; and to add to the difficulty, it was immovably fixed by a broad base to the pelvic tissues. I removed as much of the cyst as possible, and all the unhealthy tissue; stitched its base to the parietal incision, and closed what corresponded to the abdominal cavity. The patient recovered from the operation, and was put on a steady course of hepar for some months. A year subsequently I re-opened the abdomen, to excise the remnant of the cyst wall, which had continued to secrete pus, and was causing repeated attacks of septic pneumonia. There lay the sinus track, about the size and length of a finger of a glove. All around it, every atom of inflammatory exudation had been reabsorbed; there were even no adhesions to tell the story of the vast turmoil of an earlier date. I have often wondered since then whether steady persistence with hepar for months would eliminate pleural adhesions or peritoneal adhesions variously engendered. This much I can asseverate: I never saw such a widespread inflammatory area as at the first operation; and the restitution *in integrum*—so far as adhesions went—made so abiding an impression on my mind of the value of remedial measures in surgical cases as is not likely to abate.

I have already, in another place, dealt at length with the proper sphere of drugs in the elimination of ovarian cysts. Dr. Clifton and Dr. Pincott have each recorded in the journal of this society a case of ovarian tumor cured by bromide of potassium. In one of these cases the diagnosis was

certified by no less eminent an authority than Lawson Tait. Dr. Goldsbrough has also communicated to me a case of abdominal cyst cured by therapeutic measures. Dr. Madden has recorded a case of pelvic cystic tumor which entirely disappeared under the use of bovista.

As the result of my experience I am led to think that the pathological character of these tumors, rather than the individual idiosyncrasy, determines the response to remedial measures. Two years ago a patient was sent to me whose special form of ovarian cyst offered, I thought, some indications for successful therapeutic treatment. I persevered for some time with remedies, but with no result; and, at operation, found a peculiar form of dermoid cyst with a large quantity of clear cyst contents; and dermoid growths I hold to be very recalcitrant to ameliorative drug influence.

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### UTERINE CURETTAGE.\*

By H. E. BEEBE, M. D.

THIS agent as a remedial measure in some of the stubborn diseases of women, since it is justly becoming such an established and reliable adjuvant in the armamentarium of the successful gynecologist, is certainly worthy of again being considered, for some truths will bear repeating.

Its application, of course, is most frequently beneficial in diseases involving the endometrium, but not to these alone, for subinvolution, or even atrophy, may call for this procedure. In fibroids, not necessarily submucous but even in the subperitoneal or interstitial variety, it may be called for as a palliative measure. Where formerly the so-called popular local treatment, to which women were taught to submit two or three times a week with so little benefit, not often receiving even temporary relief, was used, this more

\* Read before the Homeopathic Medical Society of Ohio, at Piqua.

radical, but really much more humane and beneficial treatment, is now resorted to by advanced gynecologists.

When a thorough curettement is done, probably followed by packing the uterine cavity with antiseptic material, to remain from twelve to forty-eight hours, or in extreme cases longer, the repetition, if required at all, is seldom necessary under weeks or months, and then but seldom.

The laity, and many back numbers in the profession, favor curetting the uterus in extreme cases only, since the measure is classed by them with the major surgical operations, an honest belief which progressive gynecologists must endeavor to dispel. It is minor surgical work, and when properly done there need be but little if any danger connected with it.

Any minor surgical operation may prove serious if unskillfully performed or poor judgment be used. The successful surgeon dare not lack in good judgment, for he must know not only how to do his work well, but when to do it, and just what is necessary to be done, where to begin, and where to stop. If salpingitis or cellulitis—the latter seldom found to-day—be present, serious trouble may follow uterine curettage. As to whether the dull or sharp curette should be used, my preference is for the sharp instrument. I believe the "American Text-Book of Gynecology" is correct when it says, "The dull curette is a useful instrument in scraping out retained secundines after abortions, or portions of intra-uterine or adenomatous growths for macroscopical and microscopical examinations. The sharp curette is a much safer and more efficient instrument for this purpose. . . In endometritis the hypertrophic membrane should be removed with a sharp curette; blunt curettes are useless for this work. If a surgeon must use such, because of the supposed danger attaching to the sharper instrument, it is questionable whether he should do the operation at all."

One of the leading points of importance in treating dis-



ease of the uterine cavity is to first thoroughly dilate the cervical canal, never failing to temporarily paralyze the internal cervix. This primary work properly done, we will have good drainage—a very important feature in the after-treatment of the case. Why should there be trouble if proper aseptic measures have been used and free drainage be established? In what does it differ from an external wound? If the drainage be imperfect who would not expect trouble? Therefore we believe that since it is so well settled that thorough and complete drainage is the very necessary feature of the work, where trouble ensues this has been neglected, or the case was one in which it was contra-indicated, possibly by some obscure lesion that the expert gynecologist would have failed to detect. Accidents are liable to happen with the most skilled experts, and that, too, when least expected, but we believe they are no more frequent from uterine curettage than from many other well established minor surgical procedures, providing due care and thoroughness in doing the work be considered.

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### APPLICATION OF THE FORCEPS.\*

TRANSLATED BY B. F. UNDERWOOD, M. D.

(Continued from p. 62, January, 1897.)

#### EXTRACTION.

**T**O terminate accouchement in this position, left posterior, it is necessary to complete the descent of the head, provoke rotation, bring the head through the inferior strait into the soft pelvis, and finally out through the vulva.

*a. Completing the descent.*—To complete the descent the head is brought upon the floor of the pelvis, if it is not already there, and retained, by traction, upon the entrance to the strait, until resistance is felt and the head can be

\* From the French of Professor Farabeuf and Dr. Varnier.

seen distending the posterior portion of the perineum; ano-coccygeal region.

*b. Rotation.*—If, in completing the descent and bringing the head to the inferior strait, the forceps of Tarnier, which leave the head free, are employed, it will be seen that the hooks will indicate that the rotation takes place backward or forward, which indication should be obeyed. If there is none, or if the head remains indifferent, or if the forceps used do not permit of the indication, it is necessary

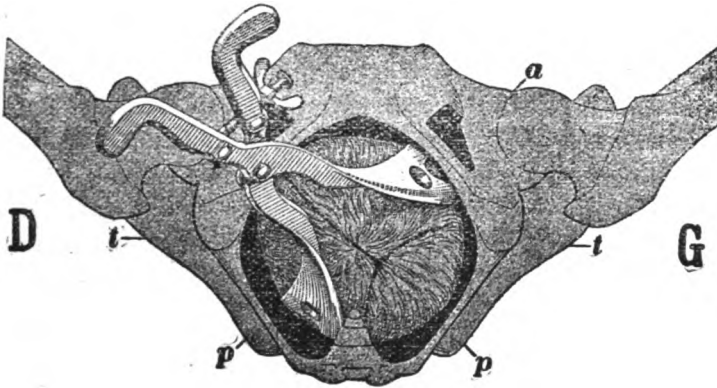


FIG. 50.

to select one of the three methods before described, page 593, November, 1896.

Whichever maneuver may be decided upon, traction should be maintained during the execution of the movement of rotation.

1. *Movement of minor rotation.*—If, at the slight risk of carrying the occiput directly backward, the disengaging the head in the occipital sacral position, well placed in the concavity of the forceps in the pelvis, is decided upon. By a minor rotation of  $45^\circ$  the forehead is brought to the right of the symphysis. The left blade will then be directed to the left and its handle to the right; the right blade to the

right and its handle to the left; the hooks will be directly transverse; figure 50 will become figure 51.

Figure 50. Vertex at the inferior strait, in occipital left posterior position. The forceps are applied, articulated, locked. To carry the occiput directly backward, it is sufficient to bring the handles directly forward.

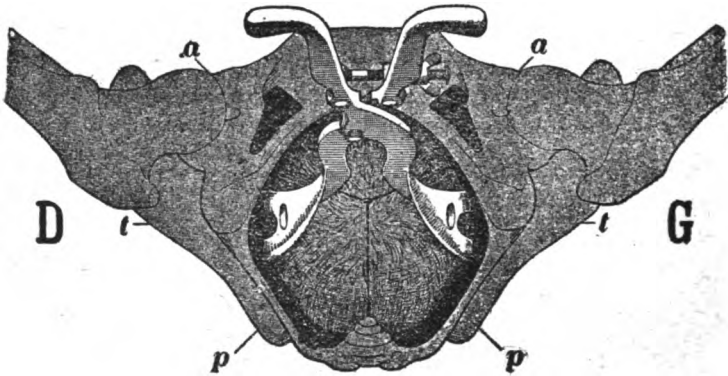


FIG. 51.

Figure 51. Vertex at the inferior strait, in the occipital direct posterior position after minor rotation of  $45^{\circ}$ .

This movement of rotation of the blades, and consequently of the head which they grasp, is obtained by imparting to the end of the handles, to the hooks, to the extremity of the fingers even, a rotary movement about the longitudinal axis of the head.

In the present position, occipital left posterior (or better, frontal right anterior), the handles, starting from the right anterior position, figure 50, describe, like the forehead, an arc of  $45^{\circ}$  and stop on the median plane in the pubic position corresponding to the frontal pubic position which the head has taken, figure 51. The position has become occipito-sacral.

Extraction will be made as described upon page 528, November, 1895, as shown by figures 18 and 20.

2. *Movement of major rotation.*—If at the risk of bringing the forceps wrong side outward in the pelvis, with the concavity turned toward the coccyx, it is deemed desirable to bring the neck back of the pubes, the occiput on the symphysis, a grand movement of triple rotation, the reverse of the preceding must be imparted to the forceps, without force, to avoid injuring the maternal walls; the liability of injury to the fetus is not so great, for the neck, even supposing that the trunk will not follow all of the cephalic rotation, may submit to such torsion without inconvenience. As in the other positions, the desired result will be obtained by giving to the ends of the handles, the crochets, with two fingers simply, a movement of cir-

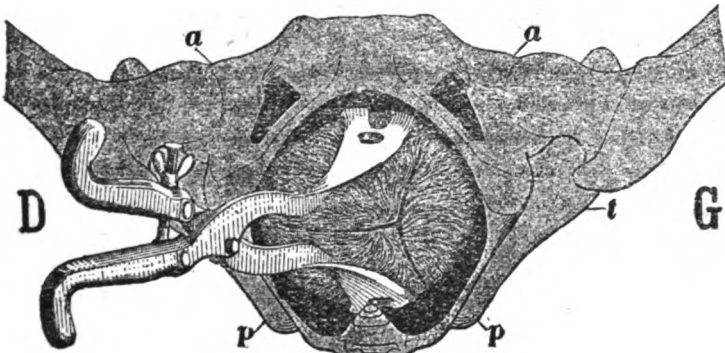


FIG. 52.

cumduction of three times  $45^\circ$  about the longitudinal axis of the head conjoined with that of the blades.

The position will have become occipito-pubic (good for the head) with the forceps in a reverse position. Extraction in this position will be described hereafter.

There are three steps to be made in executing this movement. The forehead, and consequently the forceps, are to be brought into the right transverse position, figure 52; then into the right posterior, figure 53; finally into direct posterior, figure 54.

From the first, the transverse position, the left blade will pass under the symphysis, advancing into the right half of the pelvis, the right blade in front of the coccyx, receding into the left half of the pelvis, figure 52. The forceps will be in reverse position. The half of the first stage will be completed when the handles of the forceps are turned obliquely downward in the right posterior position, figure 53, and the movement fully completed when they are vertically pendant before the coccyx, figure 54.

Figure 52. Vertex at the inferior strait in occipital left transverse position, first step of major rotation of three times  $45^\circ$ , which should bring the occiput into the left posterior position.

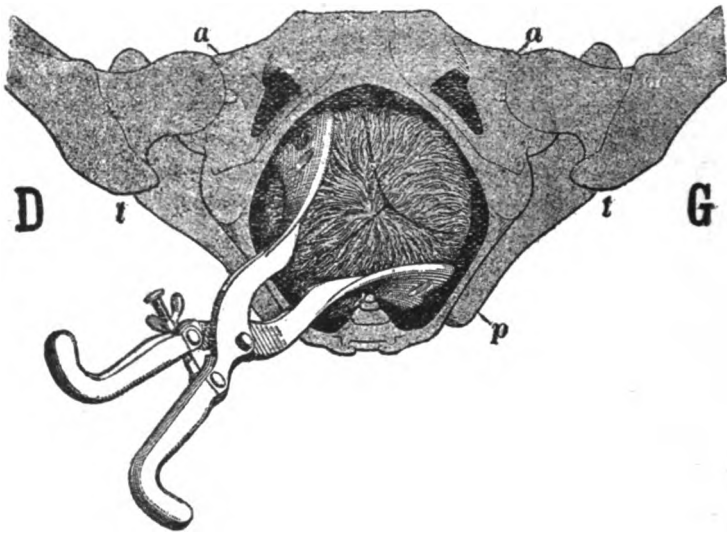


FIG. 53.

Figure 53. Vertex at the inferior strait in occipital left anterior position; second stage of the grand rotation of three times  $45^\circ$ , transforming the occipital left posterior position into the anterior direct.

Figure 54. Direct anterior position, position of extraction; third and last stage of transformation by rotation

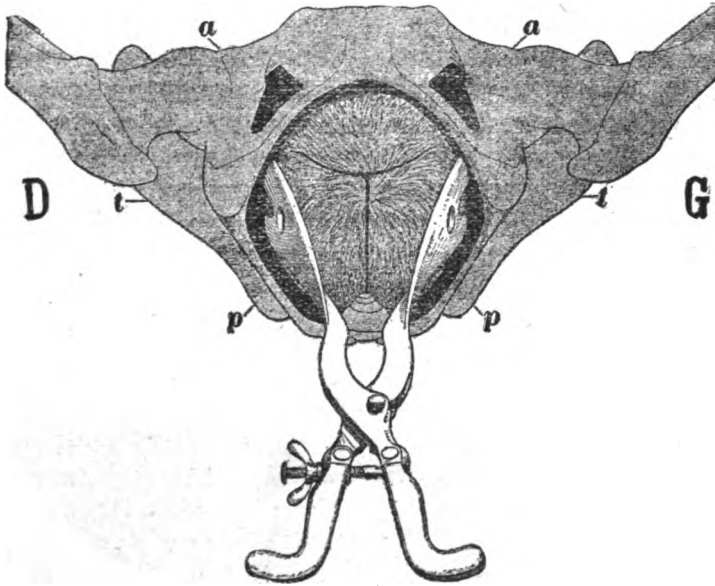


FIG. 54.

from the initial position, occipital left posterior. Forceps reversed.

### CRIMINAL ABORTION.\*

BY SUSAN J. FENTON, M. D.

TO speak of criminal abortion, I should like to be possessed of the eloquence of Demosthenes, and then borrow Gabriel's trumpet to sound my message forth to every physician in this fair land of ours, to waken each to his or her responsibility in this great and growing evil.

We are all of us brought into daily reminders of the evil

\* Read before the California State Homeopathic Medical Society, May 13, 1896.

consequences of abortion. A large percentage of our women patients are suffering as a result of that most pernicious practice. Diseased uteri, ovaries, and tubes cry out loudly against it. Etheridge says, "Among the more common local results of abortion are acute and chronic diseases of the uterus, the ovaries, the tubes, and adjacent structures, from a more or less marked septic infection. Such diseases are endometritis, acute cellulitis, pelvic peritonitis, pelvic abscess, salpingitis, pyosalpinx, oöphoritis, etc."

He also says, "There is scarcely a single manifestation of the so-called functional nerve-disorders, from slight irritability of temper or mental depression to actual insanity, that may not have its origin in a pathological condition the result of abortion."

Lusk says in his work on obstetrics that "death as a consequence of criminal abortion is especially frequent." I quote from Guernsey: "The practice of abortion in some so-called Christian nations, and not the least in our own country, is as extensive as infanticide ever was among the most degraded heathen nations. And while the former custom is in reality no less wicked than the latter, and should be no less revolting to the maternal feelings, it obviously exerts a much more destructive influence, often upon the life, always upon the health of the mother." Hirst: "Criminal abortions, with the additional risk of septicæmia from the unskillful use of instruments, and the probability of infection from unclean hands and implements, would show a surprisingly high rate of mortality if it were possible to collect accurate statistics, which for obvious reasons it is impossible to do."

Criminal abortion is always murder, oftentimes double murder, and in the cases where it is but a single murder there is always more or less loss of health, physical and moral, to the one who escapes with her life.

It is conceded by all authorities that feticide is on the increase, and we, as physicians who would sooner cut off

our right hands than commit an abortion, are largely responsible for it, forgetting, as we congratulate ourselves because we will not commit what we know to be murder, that our responsibility does not end at the line of keeping ourselves from taking life. Shall we complacently fold our hands and say to ourselves, "I thank Thee, O Lord, that I am not as other men"; or shall we, realizing that we are all in a measure our brothers' (and sisters') keepers, battle with all our might against this monster, helping our brother (and sister) to refrain from doing that which will write murder against their name. When a woman comes into our office with the request that we help her to become rid of the little life within her, or, to put it in her own words, "to give her something to bring her around," no matter what the circumstances were attending the formation of that life, it is not enough that we say in our righteous indignation, "No, I will have nothing to do with it."

But, being just as firm in our refusal, we should, remembering that a true physician is a teacher as well as a healer, take a little time to instruct the woman, that to take that little life is just as much murder as to kill any person of any age. We should explain to her the fallacy of the belief still prevalent among the laity that there is not life until quickening, and therefore no harm to rid the womb of its contents before she has felt the motions of the child. We should make it clear to her that from the time of fusion or marriage of the two life germs, in other words, from the time impregnation takes place, there is life or there would not be growth, and that to kill it at any period of its intra-uterine existence is just as much a crime as to kill it after birth. After explaining these facts to her, and also the great danger to her own life, its liability at least to make her an invalid, a subject for the gynecological chair and the operating table, if she still persists in her wicked design, we should read her section 275 of the Penal Code of California, which says: "Every woman who solicits of any person any medicine, drug, or



any substance whatever and takes the same, or who submits to any operation or to the use of any means whatever with intent thereby to procure a miscarriage, unless the same is necessary to preserve her life, is punishable by imprisonment in the State's Prison not less than one nor more than five years."

If each one of us used the arguments at our command to the people who come to us desiring abortion, and saved them from going from our office to that of an abortionist, I believe that in a few years the number of feticides would be materially decreased.

There is another class of erring ones who, anxious to avoid childbirth, do not visit their family physician (until afterward, when they come to him to repair the damage caused by their own folly), but consult the advertising columns of our daily papers where, under the heading of "Medical" (another insult to the profession of medicine), they find numerous advertisements to choose from, such as,—“All cases of irregularity restored in a few hours.” “Germicide Capsules,” “Pennyroyal Pills,” etc., etc. All guaranteed safe and sure, and perfectly harmless. No wonder credulous human nature believes them when they are put forth so plausibly. We, as physicians, know them to be murderous death-traps; emanations from the Prince of Liars, and all bearing his ear-marks. And yet, do we remember that here too we have a responsibility? If the physicians of California, or even of this society, would unite and ask our Legislature to pass a bill making the insertion of such advertisements in any newspaper or other publication a misdemeanor, punishable by imprisonment of the editor or editors of such newspaper or other publication; if each of us were to work for it, using all the influence we could bring to bear upon the subject; sending one or two of our most eloquent members to speak before the legislative body in favor of its passage, I believe we could secure it, and thus score a great victory for the side of right, and

prevent not only many feticides, but also save many women from years of disease and suffering, and also the agony of an awakened conscience which comes to them sooner or later.

Nor does our responsibility end here, for there is another class to be saved—those who resort to an abortionist, a creature who may be male or female, but certainly is not worthy to be called man or woman.

When I was a child, the story of the slaughter of the little Jewish babes by the cruel Herod impressed me with all its atrocious horror, but it sinks into insignificance by the side of this greater crime, this slaughter of little innocent, unborn babes by these modern conscienceless Herods, often taking the lives of the mothers at the same time, and always causing them suffering and pain in a greater or less degree. A being who will engage in that dirty, cowardly, contemptible business, should receive not only our utmost contempt but our bold denunciation.

Goodell, in speaking of the duties of a physician, says: "Criminal abortion must be denounced, and that boldly, if he values the health and happiness of his fellow-creatures, and a clear conscience before God and before man."

Johnson, in a well-written article on this subject in *The American Journal of Obstetrics* of January, 1896, says: "If the murder of an unarmed man in the dark and behind his back is deemed by all good people as a dastardly and cowardly act, and if the murder of innocent and unprotected children is loudly denounced the world over, what language can be sufficient to express our disapprobation and contempt for those heartless and soulless miscreants who are in the most wholesale and cowardly manner killing countless numbers of children who are not even protected by law?"

While the law in California would seem upon reading to be of some avail in punishing the abortionist, it is made a dead letter by the ruling that a person cannot be convicted

on the uncorroborated testimony of the woman alone. So the abortionist closes his door, stuffs up the key-hole, and proceeds to do as foul a murder as ever stained a soul or debased a conscience, secure in the knowledge that his partner in the crime, and the only witness of it, no matter what sufferings he has entailed upon her in her ignorance, is powerless to invoke any punishment upon him.

We should work for an amendment to that law, and never cease until the abortionist shall receive his just desert like any other murderer. Meanwhile, knowing such a moral leper to be in our community, we should, as Goodell says, denounce him boldly. If we were united in this matter, the abortionist would soon find public sentiment so against him that it would be impossible for him to pursue his vile calling.

Let us, then, be alive to our responsibilities in this matter, and, living up to the best principles of our high and noble calling, act in concert to suppress this inhuman and infamous practice.

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### IS IT ALL A FAD?

BY C. D. CRANK, M. D.

FOR many years the medical fraternity has been hard at work endeavoring to find a sufficient cause or explanation of the more frequent sickness and greater mortality attending the bottle-fed infant. The fraternity finally reached the almost unanimous opinion that it was owing to the caseine of the cow's milk, as regards both quantity and quality. The manufacturing chemist, quick to anticipate the necessities of the medical profession, responded to the occasion, and a reign of "peptonizing" "pre-digesting" and "humanizing" followed, until the profession almost came to believe that breast milk was a "superfluity"—a superabundance of Nature's good things—and that the chemist had solved the great problem of infant dietetics.

But the babies continued to sicken and to die ; other changes were made from time to time "modifying" both constituents and properties until we possessed what claimed to be a physiological equivalent for human milk. And yet there was no decrease in the amount of sickness, and the same fearful death rate continued to stand as an appalling witness against the "substitute."

One fine morning we were awakened from our disappointment by the cry of "Eureka—Eureka! there are germs in the cow's milk!" The germ theory is being rapidly accepted as an all-sufficient explanation for morbid conditions, and it was at once seized upon as the logical solution of the infantile problem.

The chemist was relegated to the rear and "peptonizing," "pre-digesting," and "humanizing" lost their euphonious sound. "Sterilization" became the word. Every progressing physician sounded it in the nursery, and no public institution was complete without its sterilizer. Our medical journals contained sterilizer advertisements on one page and an editorial on another, replete with statistics confirming the wonderful efficacy of the process, and exhibiting greatly reduced mortuary rates in public institutions. Why is it that enthusiasm which attends the first application of every newly discovered principle tends to exaggerate the desired results?

The sterilizer sterilized, there was no exaggeration about that, but the destruction of the bacteria was not followed by the happy results claimed and which the profession had reason to expect.

"What could the matter be?"

Pending the solution of this question, the sterilizer went out of the window to join the "peptonizer," "pre-digestor," "humanizer," and other infallibles.

The sterilizer craze was followed by a line of rational research, when it was found that the process of sterilization, which necessitated a temperature of 212° F., so altered the

quality and constituents of the milk as to render it unsuitable for infant digestion ; that the process of germ killing involved the life of the infant, as well as the life of the germ.

What a sad awakening !

But it was still claimed by some that the principle involved was the correct one. But to overcome or provide against the deleterious effect of the high and continued temperature upon the milk was an insurmountable obstacle. The chemist, who seldom fails to successfully respond to the call of the medical profession, was of no avail in this emergency. He kindly offered innumerable substitutes in the way of patent baby foods, all of which received the usual indorsements of the doctors, and were largely employed by them. The truly faithful were more closely cultivating the acquaintance of the ubiquitous microbe ; and were pleased to discover that in this instance its genius and power had been greatly overestimated. That we had been fighting this devil with too much fire. That a temperature of not more than  $140^{\circ}$  to  $160^{\circ}$ , and then quickly dropped to a temperature of  $50^{\circ}$ , was sufficient to paralyze all ordinary germs, bacteria and bacilli, that were at all inimical to infantile health and life, and that this degree of temperature would not alter the gastronomic, chemical, or nutritive properties of the cow's milk. Wonderful discovery !

But the old term "sterilization" was no longer a word to conjure with. We must give the new process a new name. And so the low-down method was called "pasteurization." It was not received with the same *éclat* as was its predecessor. Not that they had any fears of bacteria which might not have been paralyzed at a temperature of  $140^{\circ}$ , but because the nursery had lost faith in the bacteria business altogether.

And now comes "Leeds" with a claim that we still overrate the destructive influence of the unseen enemy ; that a temperature of  $160^{\circ}$  is unnecessary for ordinary use, adding

"that the whole tendency of the labors of those engaged in improving the quality of the milk supplied by dairies for infant feeding is to a lower temperature." The very latest statement is that no degree of heat is needed for sterilization, for it can be thoroughly accomplished by filtering the milk through cotton.

Where are we at?

Where are we coming to?

Is it all a fad?

"Earth is sick and Heaven is wearied of man's inconsistencies." And yet we must be patient with ourselves. It is line upon line and precept upon precept. No, it is not a fad. The problem of infant dietetics and nutrition is neither a simple nor a single one. We are just beginning to grasp a few of the fundamental principles upon which it rests. The experiences to which I have thus briefly referred are but stepping stones marking the progress of the work. It contains a combination of factors of which the kind of food is only one.

Chagrin has followed disappointment, and will continue to do so as long as there is undue enthusiasm over any one factor at the expense and neglect of others.

As Rotch has so wisely said, "There will surely be a reaction which will relegate to its proper place everything built upon single factors of the problem before us."

No, not fads, but healthy reactions which are full of promise and encouragement to the intelligent student of pediatrics.

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#### PERSONAL.

Dr. B. F. Underwood, editor of the HOMEOPATHIC JOURNAL OF OBSTETRICS, has given up general practice to devote himself to medical gynecology and neuroses and will open a convalescent home near New York. Practitioners desiring to consult with the doctor may address him at 102 Fulton Street.

## Materia Medica.

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***Rumex Crispus in Summer Diarrhea of Children.***—Stools brown and watery, always accompanied by incessant dry cough and debility.

***Kreosotum in Cholera Infantum.***—Greedy drinking and constant vomiting; belching and hiccoughing when carried. Child resists tightening of anything around the abdomen.

***Alumina in Constipation of Children.***—Atony of the rectum: no inclination for stool. The stools light in color from inactive condition of the liver. The keynote of the remedy is atony.

***Trillium Pend. in Post-partum Hemorrhage.***—Profuse hemorrhage, prostration, vertigo, palpitation, a sense of sinking at the pit of the stomach—suited to women who always flood after labor.

***Apocynum Cannabium in Albuminuria of Pregnancy.***—Dropsical conditions, slowly acting kidneys, urinary secretion suppressed, weakness, depression, drowsiness, and labored heart action.

***Rhus Tox. in Scarlet Fever.***—Next to belladonna in frequency of usefulness in scarlet fever is rhus tox., but there will never arise a doubt as to the choice between them. When rhus is required, the skin is rough, and the general condition typhoidal.

***Chamomilla in Leucorrhœa.***—Yellowish, watery, smarting, and vagina feels raw, as if internally excoriated. Aggravated after a meal. The pains make her almost furious and she will snap the head off (figuratively speaking) her best friend when in pain. Cannot speak a pleasant word or give a civil answer when ordinarily "off."

***Ustilago in Ovarian Pains.***—Burning pain in the ovaries shooting down the legs, intermittent, worse in the left; swollen

and sensitive to touch. Concomitants : menses too frequent, profuse and long duration, discharge dark fluid blood or clotted and foul smelling. Cervix soft, tumefied, os patulous. Leucorrhœa yellow or dark, offensive. Especially suitable during climaxis and to tall, slim, fair-complexioned women.

***Kali Carbonicum in Threatened Abortion.***—Dr. Danforth.—Impending abortion, with pains from back into buttocks and thighs ; discharge of coagula ; habitual during second or third month. After abortion, when there is a great weakness of back and lower extremities, dry cough, long continued sweats, attacks of chilliness resembling ague, chronic inflammatory condition of the uterus with nausea and vomiting.

***Palladium in Ovaritis.***—Dr. W. G. Fralicke.—Headache in places, inclination to weep, sallow complexion, blue half-circles under the eyes ; swelling and induration of right side of abdomen ; right ovary swollen and sensitive : drawing in right ovary downward and forward ; bearing down ; yellowish leucorrhœa ; ovaries tender on pressure ; right enlarged, also right tube ; uterus retroflexed and prolapsed, when thigh is flexed when lying down on left side.

***Pilocarpine in Eclampsia.***—Dr. H. E. Spalding.—Some ten years ago I recommended the use of pilocarpine, and see no reason to change my mind. I have used it to produce diaphoresis, and it has helped me out of some bad places. I will briefly report one case: I was to attend a woman in confinement, whose sister had just died of puerperal convulsions. She showed signs of uræmic poisoning, and I feared the necessity of a premature delivery. She had flashes before the eyes, some dimness of vision, and excruciating pains in the head, coming in paroxysms. The muscles of the neck would become rigid, and pains would shoot up the back to the brain. I immediately gave her pilocarpine in  $\frac{1}{8}$ -grain doses until sweating was established, when the pain would leave, and she would be comfortable. The nurse was competent, and occasionally administered chloroform and gave the powders. I presume that, at the close of pregnancy, she took them every three or four days. One day the



baby was born, and she had no convulsions. I was giving the homeopathic remedy at the same time. I used the pilocarpine on the same principle that I use a catheter to empty the bladder; I wanted to get the water out of the system—not as a remedy, but to protect the patient while the remedy acted. I use apis, arsenicum, and merc. cor. a good deal. If it is at the seventh month, and there are convulsions, there is a better chance of saving the child than later. There is such a fatality attending the delivery of the fetus that the sooner the better. If danger threatens the sight of the mother, or she is liable to have convulsions at any time, I induce delivery. I give pilocarpine by the mouth, and never saw a bad result on the heart. I have seen congestion of the lungs result from  $\frac{1}{4}$ -grain doses.

***Platinum in Uterine Disease.***—Dr. Cowperthwaite, Med. Era.—This drug affects the uterus only through its depressing effect upon the nerve centers, but such results are so uniform and characteristic, almost invariable, that they become the chief feature of the drug's action. While its use is largely confined to those cases where uterine and ovarian irritation have given rise to the characteristic and well-known mental states of platinum, as present in melancholia, hysteria, nymphomania, pruritis, vaginismus, etc., yet the fact should not be overlooked that platinum is a most valuable remedy in induration of the uterus, fibroid tumors, and prolapsus. As a rule the platinum patient has not only the characteristic mental symptoms, but also a menorrhagia of dark, clotted blood, and an abnormal sexual appetite, while probably the most important and ever present characteristic is a painful sensitiveness of the parts.

***Ailanthus Glandulosa in Scarlet Fever.***—Med. Cent.—*Ailanthus glandulosa* has a coryza all its own. It is exceedingly acrid and excoriating, burning wherever it touches. The nostrils are sore and cracked, as are, also, the corners of the mouth (arum). The heat is intense and the bodily surface dry to parching. *Ailanthus*, though not often indicated, admirably suits those cases presenting excoriating discharges and intense fetor. It is rarely indicated except in very malignant cases, and more frequently in summer than winter. It shows an eruption of miliary rash in patches, dark or livid in color, which is irregular, dis-

appearing on pressure and returning very slowly. In typhoid or malignant cases the eruption is of a bluish or purplish tint. In low, adynamic cases there are sudden and extreme prostration, torpor, vomiting, small rapid pulse. The glands of the throat are swollen and sensitive to touch.

***Aletris Farinosa in Diseases of Women.***—Dr. C. L. Olds, Med. Ad.—Aletris is most useful in the complaints of women—weak, debilitated women, who have lost much blood, are subject to hemorrhages, apt to abort frequently. The woman has a pale, sickly, chlorotic face, is tired all the time, wants to do nothing but rest—so tired. The mind is so tired she cannot think, the body is tired. Abortion comes on from the slightest cause—there is a great tendency to abort. One symptom is that of a feeling of weight in the region of the uterus. The uterus feels as if it would fall out. As soon as abortion comes on there is much bleeding. The uterus may fill up with dark clots of blood—then these will gush out, and this copious flow is followed by oozing, oozing, for a time until the uterus again fills up and the clots gush out. Everything points to the weak condition of the pelvic organs.

The remedy is useful in menorrhagia with these symptoms, in these debilitated subjects. The menses are too early, too profuse. Gushes of blood are followed by oozings—the uterus fills up with black clots and occasionally gushes forth and again oozes. There is a weak condition of the uterus.

Chlorotic girls have amenorrhea, with this general weak condition, weariness of mind and body, lassitude, bearing down pains in the pelvic regions. The menses do not appear, but she has leucorrhœa. There may be a bruised pain in the right ovary.

Aletris is useful in prolapsus uteri from relaxed condition of the ligaments, with general symptoms like the above.

The digestive track also seems to be in a relaxed condition. The least food causes distress. She takes food into the stomach and it makes her deathly sick. She vomits bilious matter, or an hour after eating vomits a frothy white substance. There may be frothy eructations.

***Sepia in Diseases of Women.***—Dr. Dewey, Med. Cent.—Sepia is a remedy acting especially on the female organs, and it is a most valuable one ; it produces in its provings venous conges-

tion, which accounts for many of its symptoms. The general symptoms in a case calling for sepia are of the utmost importance. Thus we have characteristically the weakness and want of tone in the whole system, the yellow complexion, the yellow saddle over the nose, the sunken dark-ringed eyes, the relief from violent motion, due probably to the toning up of the venous system by such, and the amelioration in the middle of the day. These are all grand characteristics of the remedy ; when they are present the other symptoms will be found to correspond with the drug most beautifully.

The menstruation of sepia may be of almost any combination, late and scanty being the most frequent ; they may be early and scanty or early and profuse—discolorations of the skin attending menstruation are characteristic, the flow is apt to be dark, the menses are preceded by aching in the abdomen and by colicky pains. Amenorrhea in those of distinct sepia temperament where there is extreme sensitiveness to all impressions.

The leucorrhea of sepia is yellowish green in color and somewhat offensive. It may be milky, it is worse before the menses and is accompanied by bearing down.

On the uterus itself sepia exerts a decided action ; the uterus is found to be enlarged and the cervix is indurated. Thus sepia becomes a useful remedy in displacements, especially prolapsus or retroversion. There is often present a sensation as if the womb was clutched and suddenly released. Bearing down pains are grandly characteristic of sepia ; the patient feels as if everything would protrude from the vulva and this sensation is relieved by sitting with the limbs crossed. There is also with all this a severe lumbo-sacral backache. *Lilium tigrinum* resembles sepia closely in bearing down and dragging in the uterine region ; with *lilium* the patient has to support the vulva with the hand ; the two drugs are easily differentiated. Though Dr. Dunham designated sepia as the remedy par excellence for prolapsus, the remedy should not be prescribed in a routine way. The symptoms are clear and one should always bear in mind (if I may be allowed to borrow from Du Maurier) the irrepressible sepianess of the remedy, that is its characteristics of weakness, sallowness, epigastric goneness and heaviness. On the ovaries sepia produces some action ; it is useful for chronic ovaritis with dull, heavy pains and the general characteristics of the remedy.

## Gynecological Etchings.

***Causes of Retrodisplacements of the Uterus.***—Dr. Hunter Robb (Columbus Med. Journ.) is of opinion that the mechanism bringing about retroversion of the uterus is very complicated. There are congenital defects, such as an abnormally long cervix or an unnaturally short vagina, distension of the bladder, impaction of fæces in the rectum extending up above the ampulla, imperfection of the pelvic floor, inflammatory changes in the uterine supports, and (most frequently) relaxation of the vaginal outlet. These causes may all be found in operation, intensifying and keeping up each other, and so forming a vicious circle. In the presence of any one of them a weak point is produced upon which intra-abdominal pressure acts, and so leads in the long run to retroversion or retroflexion. In treatment, therefore, it is not sufficient to replace a uterus, for the tonicity of the tissues has been lost.

***The Dividing Line in Uterine Cancer.***—Dr. Parmly.—There is a dividing line, and that dividing line has not yet been mentioned. I have had to answer this question a great many times. For instance, a case of uterine cancer, far advanced, was referred to me not four weeks ago. The gentleman had had the case under observation for over three years. In all those three years there had been flooding; for over a year there had been an offensive discharge from that uterus. He had never made an examination until two weeks before the case was brought to me. Now, then, where is the dividing line? What ought the general practitioner to know? What ought he to do before he takes his case to the specialist? He ought never to allow a uterus that is suspicious—no matter what his internal remedies may be, and he may use them up to that point—to fail to be examined frequently to see whether it is becoming markedly immobile in the pelvis; that is the dividing line. You may call a case inoperable after it has become fixed. The dividing line ought to be whether the uterus is becoming fixed or is still mobile.

***Drainage in Abdominal and Vaginal Section.***—Dr. Senn (Gynec. and Obstet. Journ.) employs what he calls tubular, capillary, and combined drainage. When he drains for pus, whether through an abdominal or a pelvic incision, he invariably resorts to Keith's drainage tube. Capillary drainage by means of the gauze tampon is reserved for cases in which it becomes necessary to arrest hemorrhage. When little bleeding is expected, but copious effusion of serum (the product of a primary wound secretion) is inevitable, combined drainage is practiced by Senn. A Keith's tube is packed lightly with one strip of iodoform gauze, "which," he insists, "is an enormous advantage over the older methods of tubular drainage by removing the fluid in the tube by means of a syringe." The tube keeps the canal of the wound well open, and the gauze drain is sufficient to lead the bloody serum into the hygroscopic dressing. This arrangement greatly diminishes danger from infection after operation.

***Adenomyoma of the Round Ligament.***—Dr. Cullin (Bull. Hopkins Hospital) describes a tumor of the right inguinal region in a woman aged thirty-seven. It had been noticed for eight years, but had been gradually enlarging, especially during the last two years. The pain in the tumor was of a severe cutting character, worse after exertion or at the menstrual periods. It was successfully removed, and was found to be composed of smooth muscular tissue and glands resembling those of the uterine mucosa. In places there were appearances in these glands like V. Recklinghausen's pseudo-glomeruli or adenomyoma of the uterus. Adenomyoma of the round ligament has not previously been described. The author suggests that the tumor may have sprung from an abnormal deposit of a portion of the Müllerian duct. V. Recklinghausen considered adenomyoma of uterus to be derived from remains of the Wolffian body.

***Is "Colloid" in the Peritoneum Malignant.***—Dr. Toth (Centralbl. f. Gynäk.) describes two cases of "pseudo-myxoma peritonei"; in other words, the free deposit of colloid matter, escaped from cysts, over the whole peritoneum, forming a gelatinous covering to the intestines and omentum. In one case the cyst was bilateral; one patient was forty-three the other fifty-one;

both patients are free from recurrence. Backer described a similar case where, as sometimes happens in colloid cysts, though the peritoneum was freely plastered with the material, no hole or laceration could be found in the cyst wall. It appears that the colloid deposit atrophies after the removal of the tumor.

***Operation in Cases of Incomplete Abortion.***—Dr. Stuart (N. Y. Med. Jour.) proposes a new method of operation in cases of incomplete abortion at two months. The advantages claimed are a perfect evacuation of the uterine contents with a minimum of shock, pain, and hemorrhage.

The woman is placed crosswise of the bed (made as hard as possible) in dorsal position on a Kelly cushion. The external parts and vagina are thoroughly washed with green soap and warm water, and the hair trimmed off. This is followed by an antiseptic vaginal douche. The bivalve speculum, freshly boiled, is inserted and opened, and the screws are set. The internal os is usually patulous enough to admit Bozeman's intra-uterine douche. Through this a hot creolin solution is allowed to flow, always watching to see that the return current remains free. Then all loose clots and débris are removed by the dull curette. The cavity is again washed, and this process is repeated until nothing remains but the firm decidual tissue, which clings to the uterine wall and could not be removed without much dilatation, causing much pain to the patient. The hot creolin solution is an excellent hemostatic, and is allowed to flow until it returns white. Finally, the uterus is packed from the fundus to the external os with iodoform gauze. The first gauze is withdrawn, thereby wiping out the cavity, and a second piece is firmly placed so as to stop all hemorrhage.

The patient will usually endure this treatment without a groan.

The inert uterus is stimulated to contract. The blood, unable to escape, distends the cavity and flows in between the decidua and the uterine wall, dislodging the former. Finally, the internal os dilates, the gauze is expelled, and with it all the uterine contents.

Another creolin intra-uterine douche, and if endometritis exists the gentle use of the sharp curette and a gauze drain complete the work.

Contraction and involution of the uterus go on rapidly.

***Amenorrhea Virginalis.***—Dr. Edelheit (Wien med. Presse) claims to have discovered a new disease to which he gives the name of amenorrhea virginalis. He states that it is in no way connected with cessation of menstruation from chlorosis, anæmia, etc., but is in itself a primary and serious affection. It occurs in young women, and the first symptom is the amenorrhea, which may or may not be associated with vicarious menstruation. After a while cardiac symptoms supervene, especially palpitation, dyspnœa, and cyanosis; eventually the right heart fails, and œdema and death result. The author quotes two fatal cases, the patients being twenty and twenty-three years old respectively. In a third œdema of the lungs supervened acutely, and was only relieved by venesection, after which menstruation returned and became regular, the patient recovering; in all cases some good resulted, temporarily at any rate, from blood-letting. In a fourth case the patient married without the menses having reappeared; she became pregnant in a month or two, and all the symptoms—palpitation, headache, angina, dyspnœa, etc.—vanished. This girl had epistaxis at monthly intervals. The only pathological changes found after death have been hyperæmia of the endometrium, and in one case cystic degeneration of the ovaries. Edelheit considers that the suppression of the menses leads to general plethora, cardiac hypertrophy, valvular incompetence, and finally enormous pulmonary congestion.

***Relations Between Ovulation and Menstruation.***—Dr. Bossi (Annali di Ostet. e Ginecol.) reports four interesting cases which go to show that the problem regarding the relation of menstruation to ovulation is even more complex than has been commonly thought.

In the first case the patient, a married woman of twenty-five, had suffered since she was seventeen from enterorrhagia occurring monthly associated with hysteriform attacks (also monthly). Since marriage the bleeding from the anus and other troubles had become worse, and coitus was impossible. It was found that the vagina was absent, and that the uterus and ovaries were infantile in type. An unsuccessful attempt was made to establish a vaginal canal.

In a second the woman, aged thirty-seven, had at first menstruated regularly, but later had suffered from menorrhagia. Curettage was twice performed, but without effect. Then vaginal hysterectomy was performed, and during its performance no trace of either ovaries or tubes was found. Two hours after the operation the patient nearly died of hemorrhage from the abnormal arrangement of vaginal vessels which was present.

In a third case there were periodic (monthly) convulsions, which had lasted for three years (since the age of seventeen); there was absence of the vagina, the uterus was infantile, and the ovaries lay in the inguinal ring, one on each side. There was complete amenorrhea. Both ovaries were removed, and the convulsions ceased. The ovaries were large, and each showed a recent corpus luteum.

These cases, as well as the fourth, show that no rule can yet be laid down regarding the relations of ovulation and menstruation.

The second case especially is interesting and puzzling, for notwithstanding the absence of tubes and ovaries, hysterectomy was necessary for menorrhagia.

**Medical Diagnosis in Gynecology.**—Dr. Etheridge, Med. Fortnightly.—Two things are of special significance: Headache and backache. With the head there are a few simple rules, often ignored, yet of extreme importance from a diagnostic and therapeutic standpoint. Of particular import is the locality. Thus (1) a coronal headache means (a) pelvic disease, or (b) stomachic disorders—mostly the former, (2) a frontal headache signifies (a) some error of digestion, or (b) a local trouble in the nose—hence is not of gynecological importance. (3) An occipital headache depends upon (a) some kidney lesion, (b) trouble in the bowels, chiefly constipation and absorption of poisons, or (c) rarely, some cardiac disease. (4) A temporal headache may be due to (a) neuralgic conditions, in which instance it is found on the same side as the local irritation. (5) A general headache may be (a) syphilitic, (b) rheumatic, (c) febrile, (d) malarial.

The patient who complains of a "pain in the small of the back" should be made to definitely state the seat of pain, as "the small of the back" with women means any part from the occiput to the



coccyx; and exact location means much to the diagnostician, because it may be said that pain in the back depends always upon some derangement of an organ which lies anatomically in front of the painful region. The upper dorsal pain indicates diseases within the chest. The lower dorsal pain points to disturbances in the stomach or duodenum—frequently to the gastro-duodenitis which complicates pelvic disease. Lumbar pain depends upon (a) kidney lesions, (b) colon troubles, or (c) disease of the small intestines. A fixed, boring, dull pain at the lumbo-sacral junction points invariably to uterine disease. Sacral pain accompanies disorder of the ovaries, tubes, or bladder, or all of them. And pain in the coccyx is a sign of rectal trouble.

The chest should also be carefully examined, as cardiac and pulmonary disease may so complicate pelvic derangements as to completely overshadow them.

So also the stomach should receive most careful attention because gastric disturbances which terminate in marked anæmia may be the chief cause for the symptoms which are presumed to be dependent upon pelvic disease. Fermentative dyspepsia, as evidenced by the evolution of gas and acid eructations, may be the sole source of trouble even when the patient complains most of the pelvis. In such cases if the disease of the stomach be not cured it is wholly impossible to relieve the gynecological trouble.

Very careful attention should be paid to the abdomen. Tympanites and swelling are often exceedingly deceptive. The colon, especially the ascending portion, when the site of accumulation of fæces, has often given rise to a diagnosis of ovarian disease when there is none; relief of the long-continued constipation with its attendant absorption will often dissipate all symptoms of supposed ovarian disease.

The kidney, too, is often a source of error in diagnosis. This is particularly the case with floating kidney, displacement of the right one being frequent and misleading. It is so common as to be found in at least two or three of every fifty women examined; some have said as high as five or six. It is a frequent source of "gynecologic discomfort." But it is chiefly the non-elimination of excretory matter through deficient kidney action that gives rise to many of the ills from which women suffer. The urine should,

therefore, be examined in every gynecological case. Here the centrifugator will be found of much value in making a speedy diagnosis.

As already mentioned anæmia is one of the greatest disturbing elements in diseases of women. The blood should for this reason be invariably examined with the hemometer. If the blood be found deficient the condition must be corrected before we can hope to be of much service in overcoming the pelvic disorder.

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## Obstetrics.

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***Puerperal Convulsions in Twin Sisters.***—Dr. Hnemanna (Münch. med. Woch.) writes of twin sisters who both bore a pregnancy well and were delivered normally. Yet both were seized shortly after delivery with bad headaches and amaurosis, then with violent eclampsia. Subcutaneous injections of morphine arrested the convulsions in both patients. Some congenital irritability of the cerebral cortex clearly existed in both cases.

***Central Lesions in the Fetus after Dystocia.***—Dr. Schultze (Centralbl. f. Gynäk.) notes how in many cases of children suffering from mental or nervous diseases it has been found that at their birth labor was difficult, or at least prolonged. Schultze and Pfeiffer, examining three infants which died shortly after delivery by forceps or turning, detected very evident nerve lesions. Multiple hemorrhages were discovered in the bulb, the medulla, and the cord. In such as survive, it is easy to understand the development of nervous diseases.

***Fetus Killed by Typhoid Fever.***—Dr. Etienne of Nancy (Gazette Hebdom. de Méd. et de Chir.) examined five months' fetus, which had been delivered from a girl, aged eighteen, on the twenty-ninth day after typhoid fever had declared itself in the mother. The child's spleen and intestines, as well as other organs, showed no evidence of the disease, and the placenta was healthy. Blood from the right side of the heart, and from the spleen, liver, and placenta was carefully examined, and cultures were made.

The typhoid bacillus was found in abundance. The fetus had really died of typical acute blood poisoning from a large dose of the bacillus before the occurrence of any local change.

**The Treatment of Chlorosis.**—Dr. Hayem's treatment consists of (a) rest in bed, which must be absolute in severe cases. This prevents the destruction of the red corpuscles, benefits the neurasthenia, does away with the nervous excitability, regulates the gastric functions, and removes the stays, which are a frequent cause of dyspepsia. (b) Diet, which is of equal importance in view of the frequent gastric troubles (generally parenchymatous gastritis). These must be relieved before prescribing a remedy. The diet must consist of milk and raw meat at first, later lightly boiled eggs, non-fatty fish, green vegetables as a purée, and stewed fruit. Bread is to be allowed only after four or five weeks.

**Intra-uterine Infection.**—Dr. Dürk (Münch. med. Woch.) reports a case in which a viable fetus was the subject of an infection with the staphylococcus as well as the typhoid bacillus. A woman, aged twenty, gave birth to a well-developed fetus in the fourth week of enteric fever. The mother recovered, but the infant died in about twelve hours. At the necropsy the skin was noted to be slightly jaundiced, the abdomen was distended, and contained 25 c.cm. of turbid fluid. The spleen and liver were enlarged. The intestinal mucous membrane was slightly injected, but there was no swelling of the lymphoid elements. Thus the exact cause of the death was not apparent to the naked eye. Cultivations were made from the liver and spleen. Two kinds of colonies appeared, the one being shown to be the typhoid bacillus, and the other the staphylococcus pyogenes albus. In sections from the spleen the presence of the same two micro-organisms was demonstrated. The author then refers to recorded cases in which the transference of the infection from mother to child has been proved. In his own case two separate kinds of micro-organisms passed over from the mother to the fetus. It is known that often early in enteric fever the strepto- and staphylococcus may be present, and under certain conditions give rise to complications. In Fraenkel and Kiderlen's case no typhoid bacilli were found in

the fetus, but the staphylococcus aureus and albus. Although it is proved that the placenta is no insuperable barrier to micro-organisms, yet their passage through it does not always take place. The easiest explanation of this transference lies in an injury to the cells covering the fetal villi. The above case was not one of real congenital typhoid fever, but an infection of the blood with the typhoid bacillus. The penetration of the bacilli must have occurred not immediately before birth but at some antecedent date, as the enlargement of the liver and spleen and subcapsular hemorrhage in the liver show.

***Uncontrollable Vomiting in Pregnancy Continuing after the Death of the Fetus.***—Dr. Fabre (Marseille Méd.) notes a case of uncontrollable vomiting in a primipara, eighteen years of age, who had previously suffered from anæmia and hysteria. The vomiting began at the fifth month of pregnancy, and had continued up to eight and a half months, with increasing weakness. The fetal heart was not to be heard, yet the vomiting continued, and medicinal means were of no avail; it was therefore decided to induce premature labor, and Krause's method (introduction of a bougie into the uterus) was employed. On the day before this was done the patient was so weak as to require injections of caffein and ether, and of 200 g. of artificial serum into the subcutaneous tissue of the abdomen. Twelve hours after the introduction of the bougie into the uterus a dead female fetus was delivered by means of forceps. The vomiting still continued, and the patient died twelve hours later. The only lesions found at the necropsy were those of recent gastritis. The case is interesting, for the death of the fetus was not followed by a cessation of the vomiting, a circumstance probably due to the fact that here pregnancy was not the sole factor, but had superadded to it the pathological state of the stomach.

***Quadruplets and Twins.***—Dr. Henry, Brooklyn Med. Jour.—In this country, statistics with reference to childbirth are valueless, due to the fact that physicians, as well as midwives, not infrequently fail to report births. It is estimated that as high as fifty per cent. of births are not reported. In Europe, it is more easy to obtain statistics, because there are laws that are enforced.

Playfair states that, "taking the average of a large number of cases collected by authors in various countries, we find that twins occur once in 87, triplets once in 7679, and quadruplets once in 555,083." \*

In 13,000,000 births investigated by G. Veit, he found that twins occurred once in 88, triplets once in 7910, and quadruplets once in 371,126 cases.

Quintuplets and sextuplets very rare. Kaltenbach states that there are twelve authentic cases of quintuplets. The London *Lancet* gives the statement of Vassgalli, who reports the delivery of six fetuses by an Italian woman upon the 115th day of gestation, at Lugano, Italy.

The following case was seen by me. Mrs. L., æt. thirty-nine years; German birth; usual weight, one hundred and twenty pounds; never well nourished, and of feeble constitution; married nineteen years.

There were four placentas with membranous connection, but no vascular communication from one to another. Each placenta had its independent sac. Their combined weight was three pounds.

The aggregate weight of the babies was sixteen pounds, as follows: first,  $3\frac{3}{4}$  pounds; second,  $4\frac{1}{4}$  pounds; third,  $3\frac{3}{4}$  pounds; fourth,  $4\frac{1}{4}$  pounds. Though small, all of them were perfectly formed. Respiration was readily established in the first one, but the second one required considerable and earnest effort to induce breathing. The third did not breathe at all, and the fourth was dead when delivered. The first born lived five days and died in consequence of asthenic diathesis. The second born is still alive and thriving on milk it nurses from a mother whose babe was eight months old when it was placed at her breast.

**Multiple Pregnancy.**—Dr. Jewett.—It is stated by obstetric writers that only one-third of all cases of twins go to term. A larger proportion than that, however, judging from my experience, do reach term. It is claimed by good authorities that, in case of a

\* Taking as a basis for calculation his statement, citing France, Ireland, Mecklenburg-Schwerin, Prussia, Saxony, and Wurtemberg.

larger number of children, three is the greatest number with which gestation ever reaches the period of viability. There are, however, instances on record in which quadruplets have been born viable.

The occurrence of albuminuria in plural pregnancies is to be expected in a larger proportion at least than in ordinary cases. It is well known that with twins the occurrence of albuminuria is more frequent than in single fetation, and with a larger number of children still the tendency must be increased.

As to the influence that determine the occurrence of these multiple births or multiple pregnancies, race is one which has probably no very great influence; yet England claims the credit of a larger percentage of multiple births than other nations. The principal causes, undoubtedly, are multiparity and heredity. Especially on the maternal side does heredity tell, multiparity not being a very prominent cause. Every doctor who has met with twins in his practice has no doubt often received accounts of similar occurrences on the part of other members of the family. And this is true of multiple pregnancy in general. The mother, however, does not have entire control of the matter.

***Turpentine in Obstetrics.***—Dr. Corrie in Med. Semi-Monthly.—Whilst we are constantly warned against the introduction of septic matter on fingers, instruments, and almost every other thing, not one word had I ever seen or heard against the great stream of septic matter that can be conveyed by the air being pumped or fanned, as it were, by the moving about of the bed-covering and clothing into the gaping and patulous parts of the parturient. As I not infrequently met cases of vaginal infection, and other mild types of puerperal trouble, which I could not account for, I determined to filter the air ere it reached the parturient's sore parts. Accordingly, I began ordering that, as soon as practicable after delivery of the placenta, the nurse should mix half a teaspoonful of common spirits of turpentine with half a bowl of warm water; fold some clean cotton cloth to form a pad about half an inch thick, and about six by nine inches superficially; saturate the pad, short of dripping, in this turpentine water, and apply it snugly over the genitals, but not sufficiently close to

obstruct the lochia ; these pads should be renewed as often as need be, and their use continued for nearly a week.

In addition to the foregoing, I ordered that the abdomen be gently rubbed morning and evening with spirits terebinthinæ, one dram, vaseline or other like substance, one ounce.

This practice seems to aid very materially in removing the soreness from the abdominal muscles, and, indeed, from the uterus and adnexa.

Immediately upon the institution of this turpentine treatment, my cases of vaginitis, etc., vanished like ghosts, and have not returned.

These "pads," too, if carefully prepared and placed, are very grateful to the patient : and I find that, by continuity of surface, they hasten the recovery of the sore vagina and uterus.

Should the lochia, however, from any cause become scanty and offensive, a twice or thrice daily douche of this turpentine-water will re-establish the flow and correct the fetor most speedily.

A pleasant and wholesome odor imparted to the parturient's bed and chamber should not be omitted in enumerating the advantages of this turpentine treatment. And this can be greatly enhanced by the addition of some delicate perfume to the turpentine water.

***To Prevent Lacerations of the Perineum by the Shoulder.***—Dr. Ross, Med News.—After great care has been taken, and every precaution exercised to prevent laceration by the head, and one is congratulating himself upon having managed matters so that the patient has escaped with perhaps nothing but a little nick in the fourchette, a final terrific pain drives the lower shoulder straight through the perineal body, and perhaps makes a rupture clear through into the rectum. An internal parting of the mucous membrane of the vagina, or a slight tear, is often thus converted into an extensive laceration. The matter of preventing tears is certainly not complete without regarding the shoulder as a pretty frequent cause, and directing some attention toward preventing the continuity of the perineal body being dissolved by it. If the head has been successfully delivered, it is well to look out for the shoulder.

The indications to be met in accomplishing the safe birth of the shoulders are these :

1. Direct the body upward into the axis of the outlet.
2. Lessen the transverse diameter of the body of the child.
3. Cause the exit of the body to take place slowly and gently.

When the mother is lying in the dorsal position the weight of the child's head, after it has emerged from the vagina, tends to drag the body downward and outward though the perineum, instead of outward, upward, and past it, as it should go. So the head ought to be supported, and the body directed upward in its outward passage. The transverse diameter of the body of the child may be easily lessened to a considerable extent by pressing upon the perineum and driving the upper shoulder against the pubic bone, thus doubling both shoulders over the chest.

The slow exit of the body may be brought about by pressing upon the head and retarding its motion during the pain that expels the body. But the pain that brings the body is usually a pretty violent one, and the movements of the neck prevent perfect control being obtained of the child, and notwithstanding all these precautionary measures the slippery parts are likely to get from under the hand, and damage is done in spite of all efforts. After delivering the head safely, I have been disappointed in the most aggravating way by finding that the shoulder has caused a tear, and have recently dropped into performing a maneuver which might be called the "cork and bottle" maneuver, as its motions are exactly like those undertaken in extracting a cork from a bottle with a corkscrew. I have found it exceedingly useful in extracting the body, after delivering the head with forceps, and in delivering the shoulders when laceration by them seems imminent, either on account of a rigid perineum, a partial tear of the fourchette, or the appearance of bright blood on the child's face, denoting an internal parting of the mucous membrane. It fulfills all the indications for safe delivery, and in my hands has been successful in enabling me to avoid tears by the shoulders. The maneuver is carried out as follows: First grasp the child's head by hooking the first and second fingers around the neck and allowing the chin to rest in the palm of the hand (the presentation being normal). Perfect control of both body and head is gained



in this way and the child's advance can either be retarded or accelerated at will. With the other hand grasp the bulging perineum and make firm pressure upward, pressing the upper shoulder against the pubic bone, and lessening the transverse diameter of the child's chest. Then delivery may be safely accomplished by pulling upward upon the head in the direction of the outlet, gently and steadily. The whole act may be accomplished in a moment, the usual interval which intervenes between delivery of the head and body allowing ample time for its performance.

***The Presentation of the Fetal Head.***—Dr. Seigneux (Rev. Med. de la Suisse Romande) reviews the controversies which have arisen as to which is the most common presentation. Views based on necropsies and frozen sections do not necessarily apply to the living woman. He therefore examined 80 consecutive cases clinically, and found that (1) contrary to opinion there are three forms of normal presentations, namely (a) anterior parietal (Naegele's obliquity), which is not uncommon, being found in 18 or 22.5 per cent. of the author's cases, usually in multiparæ (15.3 primipara); (b) posterior parietal, which, according to Farabeuf, Pinard, and Varnier is the normal type, but according to most obstetric physicians is rare, and only to be found in very contracted pelvis. Litzman found it in only 1.3 per cent. of 1800 cases, and believed that labor never terminated naturally under these conditions unless the presentation changed spontaneously into an anterior parietal. The author found this presentation in 43 cases, or 53.75 per cent., all of which terminated spontaneously, 25, or 58.1 per cent. being in primipara. Thus, far from being pathological, it is much more common than is generally supposed. Excluding cases where it coincides with extreme ante flexion of the uterus, the head engages in the pelvic brim as easily as in Naegele's obliquity or in the synclitic variety; (c) synclitic presentation. This was found 19 times, or in 23.75 per cent. The sagittal suture is equidistant from the promontory and the symphysis, the mechanism being that the two halves of the skull descend with equal rapidity, and follow the axis of the pelvic inlet. All 19 terminated naturally. Thus the

head engages by no fixed mechanism, but all three forms may be met with. (2) The dimensions of the pelvis have nothing to do with the presentation. All the 80 pelves were normal except 4 in group (a) (1 generally contracted and 3 flat rickety) 5 in group (b) (2 flattened rickety, 2 generally contracted, and 1 generally non-rickety), and 1 generally contracted in group (c). (3) The presentation is determined by the inclination of the uterine axis to the plane of the pelvic inlet. Thus the posterior parietal presentation is more common in primipara because the uterus is generally inclined backward, owing to the tension of the abdominal walls, while Naegele's obliquity is more common in multipara with lax abdominal walls and anteflexed uteri. Pelvic contraction acts indirectly only by facilitating anteflexion, which latter is aggravated by usually lax abdominal walls. (4) From the relation between the presentation and the inclination of the uterine axis one must conclude that the latter varies. (5) An overlapping of one parietal bone over the other is often observed, either with or without deformity of one of the bones. This overlapping is always quite characteristic of the particular mechanism of the presentation, the bone which becomes engaged last in the brim sliding under the other, and being more or less deformed by the presence of the pelvic walls.

***The Prone Position for Version.***—Dr. Mesinga (Centralbl. f. Gyn.) recommends the prone position for version. The genital canal is thus in a much more favorable position; the operator has more room, his arm is prone all the time, and his sense of touch and muscular feeling is much more exact than when, with the woman on her back, it is supine and some of the muscles of the forearm are twisted. The uterus is shortened and the os pressed into the pelvis; the vagina is also shortened and therefore more dilatable, so that the introduction of the hand is much facilitated. The os uteri is more easily passed, and, the back of the hand resting the whole time against the spinal column, the proper way is indicated in which to lay hold of the child's extremities. For the patient the disagreeable position across the bed is avoided. She lies at full length, with a pillow below her thorax and her head turned to one side; the operator sits comfortably on a stool by the bed-

side ; it is an advantage for him to be ambidextrous, so that there need be no turning the bed about. Such accidents as separation of the uterus from the vagina or embolism from the introduction of air into the womb do not occur. The occupation is much less painful ; the less the opposition the less the force required and the less pain, and, what is more important, the less force the more delicate the sense of touch. The passage of the hand through the vulva is the worst part, and more painful than its presence in the vagina ; the dilatation of the latter tends to dilate the os, and it is seldom hard to introduce the hand into the womb ; the shortening of the womb brings the parts toward the hand, which has not to explore so far, and the woman has less of the sensation of "raking out her bowels." Chloroform is not necessary, but can be replaced by an injection of morphine if desired. The perineum is constantly in sight, though it cannot invariably be saved, as he gives a case to show. Mensinga has adopted this method for the past eight years, with increasing satisfaction.

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## Pediatrics.

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***Congenital Hydrocephalus.***—Dr. Albert S. Atkinson.—The article by Dr. Partridge in the January JOURNAL is of especial interest to me, for I can duplicate his case of Hattie D. in every particular.

My case is Susie S., æt. sixteen. Two years ago, the following measurements were taken (expressed in inches) : Circumference of head, 26 ; diameter of head, anterior posterior, 9 ; transverse, 8 ; between eyes,  $2\frac{3}{4}$  ; ear to ear over crown, 15 ; right breast length,  $5\frac{1}{2}$  ; width, 5 ; circumference, 14 ; avolla, 3 ; left breast length,  $4\frac{1}{2}$  ; width, 4 ; circumference, 11 ; avolla,  $2\frac{1}{2}$  ; hydrocephalus, incontinence of urine, infantile paralysis, lateral curvature, rachitis.

She has sparse hair. Her feet are deformed as in Dr. P.'s case, due no doubt to spinal pressure, as there is no talipes. Can use either hand equally well. Is intelligent, though cannot read or write, as she is nearly blind and her parents are very ordinary people. I mean by being intelligent that she has her mental powers

unimpaired and could learn were proper teachers available. Defecation is under control. Micturition involuntary, and because of this patient is kept dressed in accordance. She is therefore absolutely devoid of modesty. Is not, however, vulgar nor obscene.

Has no use of her lower limbs and can move in her chair only by raising herself on her arms. Menstruates regularly, having begun at twelve, and is free from any pain. Her breasts show development of a woman of forty and hang lax as if they had held milk any number of times. Abdomen shows "linea albicante" so that it looks as if she has been indeed a mother. Head dimensions show the hydrocephalus.

**Do Measles Relapse.**—Drs. Chauffard and Lemoine (La France Med.) question whether measles may relapse or not and whether the subsequent eruption is not a simple recession or possibly a roseola or a rubeola, or even an accidental or remedial eruption followed by true measles. Indeed, all these states may simulate a relapse. They record eleven cases of true relapse, observed during three months of an epidemic of 1895. The intervals have been quite variable : 27 days, 20 days, 12 days, 20 days, 12 days, 1 month, 14 days, 40 days, 20 days, 1 month, and 21 days respectively. No definite period can be fixed for the prodromal stage ; if the first attack be known the succeeding interval cannot be redetermined thereby.

As to the relative gravity of the two eruptions, all sorts of combinations were noticed, but none, of either the primary or second attacks were grave and malignant, complicated, or anomalous. Dr. Buequoy regards such cases as merely two stages of the same case ; the virulence of the exanthemata not being exhausted by the first outbreak.

[In one instance under observation, the first attack which occurred in a child in a family where other children were ill with measles was found to be roseola, the onset of true measles taking place some days later.—ED.]

**Tetany in Children.**—Dr. Hauser (Berl. klin. Woch.) has investigated a number of cases of tetany, spasm of the glottis, and other diseases accompanied by spasm. In six cases of tetany with spasm of the extremities, the disease exactly resembled that of

the adult. Spasm of the glottis occurred in all the cases, but was not necessarily severe or frequent. Fits were only once completely absent. As regards Erb's symptom, the author agrees that the increased galvanic irritability is the most constant and important symptom of tetany. Trousseau's phenomenon was not absent in any case. It persisted longer than the spontaneous spasm. This sign may be absent, but when present it is pathognomonic. Chvostek's symptom was marked in all cases except one, where it was seen only in slight degree. The author says that this symptom is not pathognomonic, and may be present in other children, but in its most pronounced form it is only present in tetany. Muscular irritability was increased in all but one case. The knee-jerks were mostly exaggerated. Most of the children were excitable, but the intelligence was unimpaired except in one case, where there was a slight degree of idiocy. A rise of temperature was only once noted. In only one case of genuine tetany was the child well nourished. Rickets was generally present. There appeared to be a connection between the appearance of gastro-intestinal symptoms and that of the tetany. Hence the resemblance between infantile tetany and the tetany in gastric dilatation of the adult. The author accepts the view that there may be tetany without spasm of the extremities. In such cases Erb's and Trousseau's phenomena are present. Such cases he puts down as latent tetany. Spasm of the glottis has nothing to do with tetany. As far as our present knowledge goes, treatment can only be radical where more or less marked digestive symptoms are present. A rapid emptying of the alimentary canal is here indicated.

*Simultaneous Infection with Scarletina and Measles.*—Dr. Lange (Jahrb. fur Kinderheilk.—This case is also interesting from an ætiological point of view, as the period of infection was determined precisely from the day and hour it occurred. The patient on June 22 came in contact with other children, two of whom were still in the stage of desquamation following an attack of scarlet fever, while a third was sent away on account of some catarrhal symptoms and red spots on its face. The patient was taken with scarlet fever, after an incubation period of three times twenty-four hours. On July 2, i. e., on the eleventh day, the prodromal catarrhal symptoms of measles made their appearance, and

on July 5, the fourteenth day after infection, the typical measles eruption was present. On the eleventh and twelfth days there was again a rapid rise of temperature to  $40.5^{\circ}$  C. with a recurrence of all former catarrhal symptoms, during which, however, the frequency of the pulse did not arrive at the same height as during the first exanthemata, and on the eleventh day a typical measles eruption, which was preceded by one on the mucous membranes, made its appearance. While the desquamation of the scarlet fever process was still going on, a characteristic mealy desquamation of short duration appeared on the sixteenth day, involving the face and neck. By comparing the fever curves carefully, we find two typical periods, the first characteristic of a mild case of scarlatina, the second of a more intense case of measles. As a sequel there followed a unilateral purulent otitis media, and yet later, toward the end of the sixth week, a slight serous peritonitis, from both of which the child recovered. As regards the question whether, in such cases, the exanthemata have any influence on each other, opinions differ. Johannessen, Grancher, and Besse think that scarlatina following measles has a good prognosis, while in measles following scarlatina the prognosis is very unfavorable. Fleisch, however, is of the opinion that the scarlatinal poison is modified where the measles come on later, and Steiner expresses his belief that the older infection is favorably influenced by the last one, it being unimportant whether it be measles or scarlet fever. The author denies that there is any influence at all exerted by one upon the other. He only admits that a severe form of scarlet fever preceding may so weaken the patient that the following measles may exert a dangerous influence on the weakened organization, and vice versa; but this is not to be attributed to the specific poison of scarlet fever and measles, but any disease which debilitated the patient would have the same effect.

*Administration of Ether to Infants.*—F. Woodhouse Braine.—Practitioner.—Infants are readily brought under its influence without the slightest cyanosis. The writer has found the following method of great service in estimating the degree of anæsthesia produced in so young a subject. Place the index finger in the infant's hand, and it will be found that during the earlier part of the administration the finger is grasped very tightly, the palmar reflex being active; but as insensibility approaches, the infant's

fingers gradually relax, and so soon as they become lissom the operation may be commenced. As in the case of adult patients our guide is the conjunctival reflex, so in the infant one should devote his constant attention to the amount of palmar and digital reflex action present. This method is preferable to the conjunctival test, because the conjunctiva of a baby loses its sensitiveness very quickly after being touched a few times with the finger. The infant may appear to be thoroughly insensible by the conjunctival test when it is actually on the point of recovering from the anæsthetic, and under such conditions the reapplication of the face piece will cause struggling, to the great inconvenience of the operator. The writer has never seen bronchitis due to the administration of ether produced in a baby, but he is exceedingly careful to guard against cold air being breathed for several hours after the operation. The opening of a window is strictly forbidden, and, when possible, the baby is not even removed from the room in which the operation has been performed for at least six hours, and he finds that, when these directions are strictly adhered to, there is no danger of bronchitis occurring; moreover, the tendency (if any) to sickness is greatly diminished, and this he attributes to the non-stimulation by cold air of the nerves supplying the lungs, with the consequent reflex action of the stomach.

***Hysteria in Children.***—Dr. Upshur.—Virginia Medical Monthly.—Hysteria in children is often overlooked, owing to the idea that it is a disease peculiar to women, and also to the fact that it is so varied in its manifestations. However, it has frequently occurred in the writer's practice, and is capable of developing into epilepsy and other most serious conditions.

*The symptoms* are capricious, mental, and sensory in character. Phenomena are as various as the phenomena of the cerebro-spinal and sympathetic nervous system. In the adult, there is the element of motive to mislead. In children, these symptoms are modified, motive usually being absent. Hysteria may be defined, in children as in adults, "to be functional nervous disease, characterized by special symptoms, any or all of which are related in varying degree to abnormal psychical conditions." It is only necessary that the mental condition of the child shall be developed sufficiently to appreciate good or evil, as affected by its environment.

Before puberty the disease is abortive, as compared with the manifestations in the adult. The symptoms are not so wide in range, but phenomena of a grave character are observed, as severe spasm, amblyopia, paresis, etc. Children are more emotional than adults, the emotions less under control, and the author does not doubt that many of the conditions considered as temper, screaming fits, wind colic, etc., are really hysterical phenomena.

Any cause which tends to lower the stamina of the child may precipitate an attack of hysteria. Children of sturdy, healthy parents resist hysterical and other neurotic tendencies. Good hygienic surroundings, all tending to the upbuilding of sturdy health, are antagonistic to the development of hysteria.

The conditions of social life are at fault ; children are not kept back in the nursery as they should be ; they are not made in youth to bear the yoke ; we do not now so often see the rollicking, old-fashioned child, who is seen, but not heard. The modern child is precocious and pert. The nervous system to-day does not have thrown around it the conserving influences of a generation or two back. Bad influence on their health through ruin of digestion, from too much sweets and other improper articles of food, irregular hours of eating and sleeping, are destructive of health, especially in the direction of the nervous system.

Various conditions of the sexual system may predispose and excite hysteria. Care as to cleanliness, reflex irritation in boys from an abnormally long prepuce, leucorrhœa in girls, resulting from thread worms of acrid urine, may be causative factors ; also bad association, acting through the mind, from impure conversation among older children. Mimicry may be a cause. An outbreak is recounted as having occurred in Pennsylvania, the patients being all boys. Its manifestations were "kicking, striking, running, damaging furniture, calling everything by the same name." Many interesting reports in this direction are recorded.

*The preventive treatment* is to be followed in all cases where the knowledge of the family physician makes him cognizant of the nervous temperament in the parents, intemperate habits in the father, existence of nervous affections in other members of the family, such as chorea. The hygiene of the nursery should be as perfect as possible ; steady, gentle discipline enforced, the child not being allowed to be freakish or give way to tempers. Nutritious, wholesome food, regular hours of sleep and exercise, should be required, and guard the child absolutely from all undue excitement.



## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

**THE PRINCIPLES OF MEDICINE.** By E. R. EGGLESTON, M. D., Professor of Theory and Practice in the Cleveland University of Medicine and Surgery. The Cleveland University of Medicine and Surgery; 1896. Price \$1.00.

This little volume, which is intended as an introduction to the study of special pathology, covers the essentials of this important field of study. It is adapted for the junior class as an introductory course but will interest and instruct all students of medicine in or out of college. Among the subjects treated are: The Nature of Disease; The Causes of Disease; The Elements of Disease; Nutrition; Disease Types; Tubercle; Temperature in Health and Disease; Nomenclature of Disease; The Phenomena of Disease; Diagnosis; Prognosis.

**Announcement.**—E. B. Treat, publisher, New York, has in press for early issuance the International Medical Annual; being the fifteenth yearly issue of that well-known one-volume reference work. The prospectus shows that the volume will be the result of the labors of upward of forty physicians and surgeons, of international reputation, and will present the world's progress in medical science. The value of the work will be greatly enhanced by the thoroughness of illustration; both colored plates and photographic reproductions in black and white will be used wherever helpful in elucidating the text.

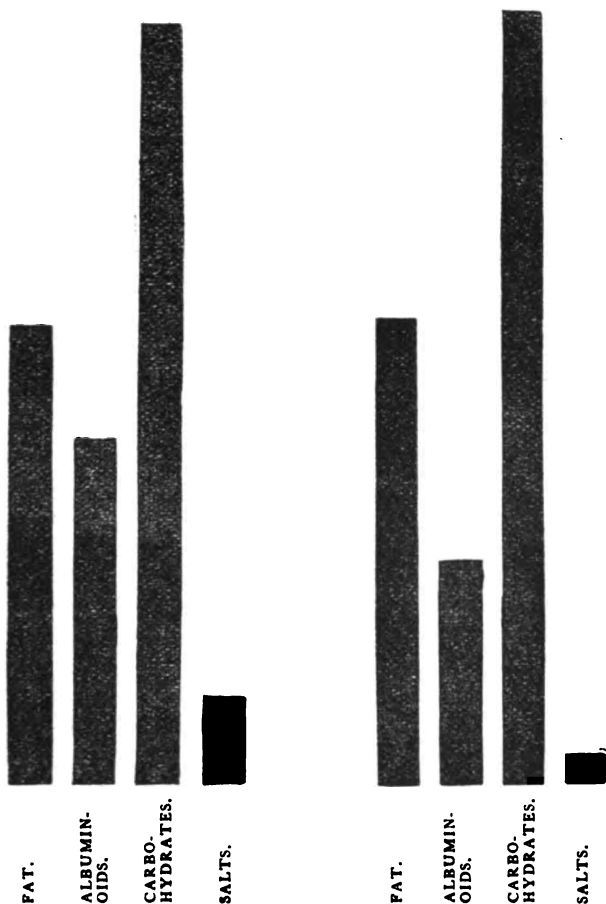
The volume will contain about 700 pages. The price will be the same as heretofore, \$2.75.

Messrs. Lea Brothers & Co. announce the early publication of The American System of Medicine. In contributions by eminent specialists. Edited by Alfred Lee Loomis, M. D., late Professor of Pathology and Practical Medicine in the New York University, and William Gilman Thompson, M. D., Professor of Materia Medica, Therapeutics, and Clinical Medicine in the New York University. To be completed in four imperial octavo volumes, containing from 900 to 1000 pages each, fully illustrated in colors and in black. Per volume, cloth, \$5.00; leather, \$6.00; half morocco, \$7.00. Vol. I. Infectious Diseases. Almost Ready. Vol. II. Diseases of the Respiratory and Circulatory Systems, and of the Blood and Kidneys. In Press. Vol. III. Diseases of the Digestive System, of the Liver, Spleen, Pancreas, and other Glands. Gout, Rheumatism, Diabetes, and other Constitutional Diseases. Shortly. Vol. IV. Diseases of the Nervous System and of the Muscles. Diseases of doubtful origin, Insolation, Addison's Disease, etc. Shortly.

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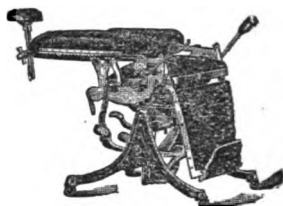


Fig. XVII—Dorsal Position.

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## SOME OBSERVATIONS ON THE SURGICAL RELIEF OF CYSTOCELE.

BY SHELDON LEAVITT, M. D.

**I**T is evident that cystocele must depend for its cure upon surgical measures. Palliation of its symptoms is possible by means of suitable supports, and these should be employed in those cases upon which we are not allowed to operate. Rarely does cystocele exist alone, but it is nearly always associated with rectocele and prolapsus uteri, for which reason we are not often called upon to operate upon it separately, but rather in connection with cervical amputation, trachelorrhaphy or perineorrhaphy. In this paper, however, I have no intention of suggesting any deviation from the usual methods adopted for relief of descensus of the parts mentioned, save in the one particular of cystocele. Operations designed to relieve the prolapsus indicated are not altogether satisfactory, and, in old and bad cases, it is probably better to perform vaginal hysterectomy as well as colporrhaphy. But in those cases where so radical an operation is either not justifiable or is refused, we must do

the best we can with the means and methods at our disposal.

I have hesitated to mention, in a public manner, the method which I am about to suggest, without having further experience with it, and in doing so I may be unwise. I have used it in several instances with most satisfactory results, and am impelled to call attention to it in the hope that others may employ it tentatively until satisfied regarding its merits. It is put forth only as a modification of existing operations, and even as such it may prove to be not altogether unknown to other operators.

The design of all operations for cystocele is to take in the anterior vaginal slack in such a way as to give good vesical support, not only for the time being, but for all time. As a means for accomplishing this we have first, and most prominent, the elliptical form of denudation, and secondly, the circular form. While other methods have been suggested for special cases, these are the most common ones for general use. To make the former, the mucous surfaces are picked up at four points, two lateral, another near the meatus urinarius, and the fourth near the cervix uteri. After dissecting off the mucous membrane the lateral edges of the wound are brought together so as to make one long longitudinal scar. The circular dissection is made in a similar manner, but usually higher in the vagina. A single suture, introduced like a purse string, is used to close the wound, thereby making a scar at a single point.

That these operations often serve a good purpose I do not question; but that they often yield unsatisfactory results cannot be denied. The elliptical dissection, when united in the manner indicated, takes in the vaginal slack from lateral directions, but does not do so longitudinally. This I believe to be a fatal defect, since there is relaxation of the mucous membrane in a longitudinal as well as lateral direction. Steltz's circular dissection, with purse string closure, is intended to overcome this defect, and doubtless

does, in a measurable degree; but the gathering of the entire margin to the one point is liable there to create an undue thickening and prominence, which may favor rather than discourage vesical pressure and ultimate protrusion.

In the modification which I am about to suggest the mucous membrane is picked up at four points, as in the instance of the common elliptical operation; but I make a quadrangular instead of an elliptical dissection, the form being either square or rhombic. The dissection is made in the usual manner, great care being exercised to avoid

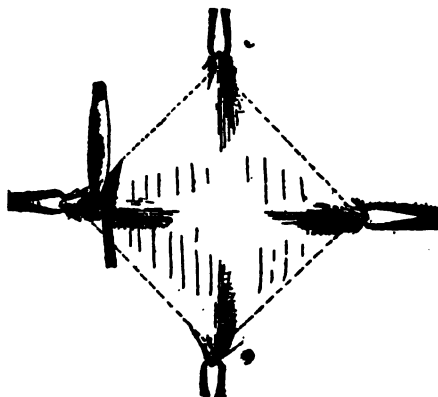


FIG. 1.

wounding the bladder. I usually begin at the urethral angle and dissect toward the patient's right, the dissection terminating at the left posterior side and the cervical angle. The mucous membrane should be removed in one piece. The form and method of this dissection are clearly shown in Figure 1. A curved needle, armed with a firm thread of silk-worm gut, is then made to pick up the four sides of the rhomb, or square, at their centers, and the suture, when fully taken, is tightened so as to approximate the four points, and then tied. This brings to a common center the four sides of the dissection, and joins the margin in such a



manner as to give the form of St. Andrew's cross. The four arms of the wound are then severally sutured with catgut, thus completing the operation. I assume that by uniting the margins of a dissection of such a form in the way indicated, not only is the vaginal slack taken in longitudi-

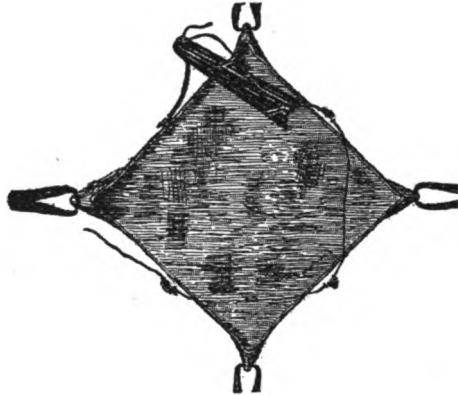


FIG. 2.

nally as well as laterally, but the underlying tissues, as well as the newly formed mucous coverings, assume such a relationship as to insure greater permanency.

My experience with the operation has thus far been most gratifying; and while I do not suppose that it will be a preferable operation for all cases, I hope it may prove to be the best for many.



## THE RELATIVE VALUE OF ABDOMINAL AND VAGINAL EXAMINATIONS IN OBSTETRICS.\*

By F. W. HAMLIN, M. D.

**T**HE keynote of successful practice of the obstetric art is asepsis. Antisepsis is good but asepsis is far better. Any method that will lessen the dangers which surround the pregnant woman should receive the earnest and careful attention of the thoughtful physician. It is an accepted fact that the most dangerous diseases that can attack a woman in childbed are those diseases which are included under the term puerperal infection or puerperal septicæmia. In earlier days puerperal fever was the term used to designate these conditions. It is now definitely settled that the various morbid processes to which the name puerperal fever was formerly applied spring from a common source. That source, in the great majority of cases, is a disease germ introduced into the genital tract of the mother either at the time of the delivery or at some subsequent period. In other words, the infection comes from without and not from within. It is not the province of this paper to discuss the subject of puerperal infection, nor, in my opinion, is such a discussion necessary. I make the simple statement of the accepted origin of puerperal infection merely to emphasize the thought that abdominal examinations, carefully made by one experienced in such examination can reduce almost to zero the death rate from puerperal septicæmia. This subject is of especial importance to physicians in private practice, as it is a well-known fact that the death rate from puerperal diseases is much higher in private practice than it is in lying-in hospitals. This fact should render our minds peculiarly receptive to any procedure which will, if rightly understood and applied, greatly diminish the mortality among puerperal women

\* Read before the New York State Homeopathic Medical Society.

and surround the lying-in chamber with all the safeguards of modern obstetrics. I intend to include under the head of abdominal examinations the external measurements of the pelvis. The question then before us is to determine which of the two methods of examination, the abdominal or the vaginal, has the greater sphere of usefulness? Which gives us the more definite and practical information? Let us inquire in the first place what facts may be determined by an abdominal examination.

It is my belief that it is the duty of the physician, especially in the case of a *primipara*, to make a preliminary obstetric examination about the end of the eighth month. In hospitals both an external and an internal examination are made. In private practice an internal examination, carefully made, is usually sufficient. Let us imagine that we are about to make such an examination, and let us note the steps of the process. As a preliminary requisite the bladder and the rectum should be empty. The patient lies on a bed or lounge, covered with a sheet and with the limbs outstretched. Her clothing should be loosened and the skirts drawn above the abdomen. The necessary manipulations may be conducted under the sheet, or through it, without exposure of the patient. The hands of the examiner should be bathed in warm water to render the touch more acute and to prevent reflex contractions of the abdominal and uterine muscles. It is well to adopt some definite order of procedure, as mistakes are thus more surely avoided. The first point to determine is the location of the back and small parts of the fetus. By palpation, applying the palmar surfaces of the finger tips to opposite sides of the abdomen, the firm resistance offered by the back is readily distinguished from the less firm resistance offered by the liquor amnii and the small parts. By applying one hand on the fundus uteri and passing downward in the axis of the uterus, thus rendering the back more convex, this difference in resistance is still

more perceptible. The small parts, also, can usually be felt as nodules which glide about under the touch. Except in the case of twins, finding the small parts in one portion of the abdomen establishes the location of the back in the opposite region. Small parts on the right indicate a left dorsal position and *vice versa*. Small parts few and hard to find point to anterior position of the child's back; small part numerous and near the middle of the abdomen usually mean a dorso-posterior position.

The second step in the examination is the examination of the lower uterine segment. The examiner, facing the patient's feet, places his hands flat upon the abdomen over the lower portion of the uterus. The finger tips are gently thrust downward into the brim of the pelvis. By this procedure we may examine the pelvic inlet and learn if it contains the presenting fetal part. If it is filled before labor, the presentation is cephalic or vertex. No other fetal part sinks into the pelvis before the outset of labor, and this sinking rarely occurs except in primiparæ. When the head lies above the pelvic brim it may be mapped out by bringing the hands closer and closer together, until the solid globular head is between them and can be rocked between the two hands. The head is further distinguished from the breech by the presence of a sulcus between the head and the trunk. If it be desired to make the diagnosis still more exact, we may determine the position of the occiput by remembering that the occiput as a rule sinks more deeply into the pelvic cavity than the sinciput. That side of the cephalic tumor which is the more prominent is, therefore, the sinciput; cephalic prominence to the right indicates a left occipital position and *vice versa*. The location of the anterior shoulder may also be determined by careful palpation. If there is any doubt as to the nature of the fetal part found in the lower uterine segment, it is well to examine the fundus uteri. This will serve to confirm or disprove the results of the examination already made.

The third step in the examination is the location of the fetal heart sounds. The stethoscope may be used with advantage. The examiner should first listen directly over the location of the upper part of the child's back. If the heart sounds are not heard, the entire surface of the uterine tumor should be searched. It is important to locate the point at which the sounds are heard with the greatest intensity. This point, as a rule, overlies the fetal heart. The location of the heart sounds serves to distinguish left from right and anterior from posterior positions. With all these facts clearly demonstrated it will readily be seen that the abdominal examination at the time mentioned, namely the end of the eighth month, is of far more value for the diagnosis of the presentation and position of the fetus than the vaginal touch. Then again the abdominal examination is of great value from the fact that by its use we may determine abnormal conditions of both mother and child at a period of gestation when such knowledge is of the greatest practical importance to both physician and patient. An expert in the practice of abdominal examinations can determine, for example, the existence of pelvic deformity at a time when measures can be instituted with every prospect of success which will insure the safe delivery of the child and the recovery of the mother, while, if the golden opportunity be allowed to pass and an abdominal examination be neglected, much suffering on the part of the mother and possible death of the child may result. In the course of the abdominal examination we may also learn much in regard to the possible existence of fetal or maternal anomalies which may complicate labor. A pendulous abdomen in a first pregnancy should suggest pelvic deformity. In multiparæ such a condition is not uncommon and may retard labor by hindering the engagement of the presenting part. Hydramnios may be recognized by the unusual size and increased tension of the uterine tumor and by the preternatural mobility of the fetus. The

location of the placenta may often be determined by palpation, and a vicious implantation of the afterbirth recognized in advance of the onset of labor. Twin pregnancies are indicated by the excess of liquor amnii, the large number of small parts widely distributed, and unequivocally by the detection of two fetal heart beats of different rates.

Another very important part of the preliminary obstetric examination is the determination of the external diameters of the pelvis. This part of the examination should never be neglected, especially in primiparæ, for, although pelvic deformity is happily rare among American women, the possibility of its existence should always be borne in mind. When the importance of measuring the pelvis is fully understood by the profession and impressed by them upon their patients, a long step will have been taken toward perfection in the obstetric art. Five measurements are usually taken in hospital practice, but of these three are the most important and will suffice in the great majority of cases. These three diameters are the external conjugate, the interspinal or the distance between the anterior spines of the ilium, and the intercrystal or the distance between the crests of the ilium at their highest points. The two diameters of lesser importance are the right and left oblique. The most important diameter is the external conjugate. This is measured from the depression just below the spine of the last lumbar vertebra behind to a point on the upper part of the symphysis in front. The pelvis under examination may safely be assumed to be ample when this diameter exceeds 18 cm. or  $7\frac{1}{4}$  inches. An external conjugate diameter below this standard is contracted at the brim. When the interspinal diameter is equal to or greater than the intercrystal, flattening of the pelvis is indicated. When both these diameters are small, there is general contraction. The average measurement for the interspinal diameter is 25 cm.; for the intercrystal 28 cm. The determination of these diameters by the pelvimeter is by no means

difficult, and when the necessity for their determination is explained to the prospective mother no sensible woman will object to the necessary examination. Thus, by the use of a preliminary abdominal examination, the physician comes to the lying-in chamber with an exact knowledge of the conditions which he must face. If any obstetric operation be necessary he knows the exact position of the child *in utero*, and every obstetrician knows what a tremendous advantage such knowledge gives in the performance of any necessary manipulation. The frequency of the fetal heart beat warns the physician when it is imperative for art to take the place of nature in the interests of the unborn child.

In all respects the physician who knows how to gain the information which an abdominal examination may give is far better fitted to conduct a labor to a successful termination, and feels himself in every way master of the situation. Then, too, the knowledge of the presentation and position of the child *in utero* gained by abdominal examination renders wholly unnecessary the frequent vaginal examinations which are such a prolific source of danger to the woman in labor. Under ordinary conditions three or four vaginal examinations in the course of the labor will be amply sufficient to determine the progress of the child toward delivery, and these examinations need note nothing further than the fact that labor is progressing normally and that the vaginal secretions are abundant. It is not necessary to pass the examining finger within the os uteri to determine these points, and thus the chances of puerperal infection may be reduced to a minimum.

Those who have never practiced the abdominal examination hold the opinion that it requires so much experience to make such an examination with any results that it is idle for the physician in private practice to make the attempt. This opinion is by no means true. In the "American Text-Book of Obstetrics" I find this statement: "The beginner should be urged to avail himself of every

opportunity for practicing this method, for, while he will find in his early practice many cases in which the obesity of the patient or the rigidity of the abdominal and uterine muscles renders abdominal palpation of no value, a large number in which the examination is inconclusive, and only a few in which he can attain a clear diagnosis by this means, yet, as his experience enlarges, the first class will steadily decrease in number, and the latter two will increase proportionately, if he is faithful in practicing palpation upon every case that comes under his charge; and the value which attaches to facility in making a diagnosis by this means in many difficult operative cases can be appreciated only by those who possess it. It is certainly a fact that to the experienced hand abdominal palpation yields results fully as valuable as those which can be obtained by digital examination *per vaginam*, and that there are but few cases in which repeated examinations during the progress of labor will fail to establish a diagnosis by palpation and auscultation alone."





## URÆMIC CONVULSIONS.

BY A. A. LOVETT, M. D.

**D**URING the earlier part of August there called at my office a young girl, aged just sixteen years, married and fully  $7\frac{1}{2}$  months pregnant.

She presented one of the worst cases of general œdema I had ever met. The feet and legs were swollen enormously and the entire body and face were very œdematous. The urine was highly albuminous, though to a less extent than in cases I had previously met. This case was remarkable for the absence of nervous symptoms, which are almost universally present in these cases. Considering the fact I had fully six weeks until term of pregnancy was complete, I was hopeful that by the judicious use of remedies she would be sufficiently relieved to render her chances good for a safe delivery. After ten days' treatment I had the satisfaction of seeing the dropsy diminished fully fifty per cent., a free flow of urine—less highly albuminous, and all symptoms much improved.

The day of her last visit to my office she walked quite a distance; also on the following morning, although I had given her instructions to remain off her feet and as quiet as possible. On the morning above mentioned she became very nervous, and about noon was taken with a convulsion from which she did not regain consciousness. On my arrival, some two hours later, I found she had already had five violent convulsions, and two more followed in quick succession. It was soon impossible to administer remedies *per orem*, and such as I did use were given hypodermatically. Realizing that all medicinal measures were doubtful, I at once prepared to bring on labor, and have as rapid a delivery as was safe and consistent. From statistics, we learn that about eighty-five per cent. of convulsions cease on emptying the womb, and, while I was doubtful of a favorable

result in the case, I concluded her only chance lay in that procedure. She was at once chloroformed, which for the time held the convulsions in check, and I proceeded to dilate the cervix. I inserted my hand fully within the vagina and with my fingers succeeded in gradually dilating the cervix until I inserted my whole hand into the womb. Then making my fist inside of the womb, I allowed it to remain until there was sufficient dilation for it to be easily removed. This procedure required fully  $1\frac{1}{2}$  hour and, while exceedingly tiresome, was very successful. The patient in the meantime, while under the influence of the anæsthetic, had only one or two slight convulsions. I then ruptured the sac of water and there flowed off an enormous quantity. Thinking the relief thus obtained would be in a measure effective, and while waiting for uterine contractions, I allowed her to come out from the anæsthetic. Immediately there followed a very severe convulsion, showing that, so far, the lessening of the pressure in the womb had no effect. My friend, Dr. Ryder, whom I had called to my assistance, now arrived and we proceeded to deliver the child. External manipulation of the abdomen was rewarded by uterine contractions, and by the aid of forceps the child was born safely. The third stage of labor was prompt and uneventful. The child was very weak and lived less than twenty-four hours. Considering everything, the production of labor was highly successful. The moment, however, the chloroform was withdrawn the convulsions returned with the former intensity, revealing the fact that we had gained little or nothing from our efforts in emptying the uterus. Our patient was in a profound stupor and entirely unable to swallow anything. Morphine was now given in several doses, until one-half grain was administered, when, after having fifteen convulsions, they ceased to return.

Profuse hydrosis was produced with the hope of eliminating the urea from the blood, and continued for several

hours, but the patient never regained consciousness, and died in about fifteen hours from the inception of the convulsion. In these severe cases the uræmic poisoning is so intense as to render any effort we may make almost ineffectual. One serious mistake was made in the case, and that was that I did not, when I first saw the case, immediately put the woman to bed and confine her there until the albuminuria was overcome and she was relieved of dropsy. In this case that would have been difficult, and, perhaps, in her surroundings, impossible, but it is an all-important part of the treatment and should have been by no means neglected. The prognosis is exceedingly grave when the patient falls into profound stupor after the first convulsion, and we can have little hopes of effecting a cure.

A few weeks after date of above case it was my fortune to meet a second case, which responded promptly to treatment and recovered. I may add here that I have noticed that, when I have had one unusual case, another similar one was sure to occur in a short time. This is an instance of the fact referred to above.

On October 4 Mrs. H. called at my office for advice and, if necessary, treatment for her condition. She was about seven months pregnant. For some two months prior had noticed swelling of the feet and ankles, scanty urine, and general indisposition. The swelling had gradually increased until the present time, when she presented a case of general œdema. The swelling was enormous, the face being almost beyond recognition. Tongue was heavily coated, cracked down the center, and the struma dark red. She was very dull and indifferent. My diagnosis was not difficult. So I immediately sent her home and confined her to bed, and placed her on an exclusively milk diet. I prescribed for her what I had before found beneficial in similar cases, viz., the bichloride of mercury, in very minute doses, namely, the one-thousandth of a grain, doses every three hours. On Monday I examined her urine and found it fully fifty per cent. albumin.

The microscope revealed numerous fatty and granular casts, renal and tubular epithelia showing I had a case of interstitial nephritis.

On Tuesday following the urine was almost entirely suppressed, and during the evening she was taken with a severe convulsion, from which she regained consciousness in part. Shortly after my arrival on the scene and about two hours from the first attack she had another convulsion quite severe, from which she regained consciousness only after several hours. I administered cupric arsenose, one-thousandth of a grain per dose; repeating the same every thirty to sixty minutes. Then, after bathing her in hot water, I wrapped her in a wet sheet and placed her between woolen blankets, and then applied heat until I produced a very profuse hydrosis. By this time the counsel whom I had called for arrived, and as our patient was resting quietly, the question of producing a premature labor was delayed until further urgent indications arose. No more spasms occurred. I endeavored to produce a free catharsis, but was only imperfectly rewarded for my efforts.

On Wednesday she passed only about one-third pint of urine, which was fully seventy-five or eighty per cent. albumin. I continued the same treatment, diet and sweating, the latter twice per day, and had her drink freely of distilled water. The cuprum ars. was given now only every three hours.

On Friday she was much better in every respect: The urine been had increased to  $1\frac{1}{2}$  pint, and the albumin had been reduced to less than twenty-five per cent. She was feeling quite well, sleeping well, and the œdema had almost disappeared, only a little remaining in the face.

By the 13th the albumin had decreased to eight per cent., but by the 14th I noticed without any cause an increase of the albumin to forty or fifty per cent. This continued until Saturday the 18th, when she was taken in labor, and in a few hours was safely delivered

of a 3½-pound child. The albumin has gradually diminished since, and at this writing (October 26), is still ten or fifteen per cent. The woman is doing as well apparently as after an ordinary confinement. Microscopical examination still shows hyaline and granular casts, also renal epithelia, though a great deal less numerous than during her pregnancy. This, I think, reveals to us a chronic case of interstitial nephritis, and I shall follow the case for some months, if permitted, to demonstrate how far, if possible, the nephritis is dependent on the pregnancy. I am inclined to think that most of our cases of eclampsia are dependent on a previous undiscovered condition of renal disease. In this case the continued daily sweating may probably have been a prominent factor in bringing about a premature labor. The conditions favor an early and easy labor, and undoubtedly the above means assisted. The child, which by the way is deformed, is doing well and promises to live.

I want to call attention here to the use of cuprum arsenicum in cases of uræmic convulsions. If administered in doses of one-thousandth of a grain, repeated every two or three hours, it is not only effectual in controlling the spasms, but has a marked action on the kidneys, and will often prolong life in these desperate cases. Dr. W. C. Goodno of Philadelphia first called my attention to this application of the drug, and I am well satisfied with its use in the above case. It, however, is of little use in uræmia not complicated with convulsions. This can be readily understood by anyone who has studied the pathogenesis of the drug or of the drugs of which it is compounded.

March 1, 1897. The lady treated above has fully recovered, and no trace of diseased kidney is shown by chemical and microscopical examinations of the urine at this date. I have made several examinations and they all show a normal condition.

## IODIZED PHENOL IN GYNECOLOGICAL PRACTICE.

BY E. E. SNYDER, M. D.

**I**ODIZED PHENOL is a substance produced by the fusion of the crystals of carbolic acid with those of iodine in about the proportion of three to one. This combination, while it retains some of the properties possessed by each substance that enters into its composition, possesses some that are in a measure distinct from these and peculiar to itself.

Without entering into details of the general action or properties of this substance, I wish to speak briefly of its usefulness as a topical application in certain forms of uterine disorders. While it may be used locally, with good results, in a variety of uterine affections, I will speak of it now especially as a substitute for curetting.

I will cite a case that will illustrate the comparative merits of uterine curetting and treatment of the endometrium by iodized phenol: Mrs. A. came to me in June, 1892, for the treatment of persistent metrorrhagia. She was thirty-two years of age, was married, and had a miscarriage ten years before, but otherwise had never conceived. The metrorrhagia began four years previously, and most of the time had been very severe.

Examination showed marked enlargement of the womb, the cavity being  $3\frac{1}{2}$  inches in depth; there was slight retroflexion and marked fungoid degeneration of the endometrium. The lining membrane was soft, swollen, and inclined to bleed profusely from the slightest touch, and there was considerable loss of blood every day, rendering the patient very anæmic and debilitated, necessitating her confinement in bed part of the time. She said she had been thoroughly curetted three times by an eminent gynecologist, and kept in bed for some time after each operation. This was followed each time by a cessa-

tion of the excessive flowing and some improvement of the general health, but in a few months the unnatural flowing returned, and gradually increased until, in six or eight months, it would be as bad as ever. This result followed each of the operations, the last of which was about ten months previous to her consulting me, and the metrorrhagia was then worse than it had ever been.

She became discouraged with the treatment of curetting, and came from a distant city to consult me and see if I could not give her more effectual and permanent relief, as I had been her physician before her marriage.

From previous experience in the use of iodized phenol, I determined to test the local use of it in this case. After removing what blood I could from the uterus I made several applications of this preparation in full strength, to the endometrium, by passing to the fundus of the uterus a pencil of absorbent cotton saturated with the iodized phenol and allowing it to remain a few minutes each time. This promptly checked the excessive flow of blood, and made a decided impression upon the endometrium, but produced no pain; in fact, it seemed to act in a way as a local anæsthetic. I then introduced to the fundus of the uterus, by the applicator, a pencil of cotton saturated with one-third strength of the iodized phenol, with a cord attached and held in position with a vaginal tampon, to remain twelve hours, when the patient was to remove all the packing. This application of iodized phenol was repeated every third day until six treatments had been made. There was very little bleeding after the first treatment, and none after the second. She then returned home, to report to me in case any of the trouble returned. Not having heard from this patient in over four years, I wrote her a few weeks ago, and in reply she stated that there had been no return whatever of the old trouble, and that she had remained in perfect health ever since she saw me last.

This is a type of a number of similar clinical cases that

I might report, that were successfully treated in this manner, but it is sufficient to illustrate the advantages of this treatment, in certain cases, over curetting.

Uterine curetting has become a very popular treatment of late for various affections of the endometrium. There are, no doubt, certain cases where curetting is the best known treatment, but in fungoid degeneration of the lining membrane of the uterus, small multiple mucous polyps, and certain forms of chronic endometritis, I think the local use of iodized phenol is decidedly preferable and renders curetting unnecessary.

In beginning the employment of this treatment in my practice, it was only partially successful, which I found was due to the fact that I was not thorough enough in its application. I was too timid about using it in sufficient strength; and I did not repeat its application often enough to make sufficient impression upon the endometrium to effect a lasting cure.

I have also cured a number of cases of membranous dysmenorrhea by dilating the cervix, and applying this remedy, which I consider better practice than curetting, but the cure depends, in these cases, largely upon the thoroughness with which the treatment is done.

Some of the advantages of this treatment over curetting are: it does not require the use of an anæsthetic; it does not confine the patient in bed, ordinarily, after treatment; it is not dangerous in any way; it is not nearly so serious and dreaded a matter in the mind of the patient as the operation of curetting; it is less liable to be followed by unfavorable cicatricial contractions; and it is more apt to produce complete and permanent cures.



## MODIFICATIONS IN THE TECHNIQUE OF VAGINAL HYSTERECTOMY.

BY FLORENCE N. WARD, M. D., SAN FRANCISCO.

**I**T is needless to enter upon a consideration of the value of vaginal hysterectomy. As an operation, not only has it won for itself an approved and accepted position as a surgical procedure, but its field of usefulness has extended so as to include almost all lesions of the pelvis. It now remains for us to still further improve its technique so as to place it on a par with the latest achievements in modern surgery.

To the French surgeons must be accorded the credit of excelling all others both in technique and results. Before analyzing the different steps of the operation, and suggesting improvements, it is well to look back over the evolution of hysterectomy, to note the changes that have taken place in its development before being crystallized into the best methods of to-day.

Langenbeck is credited with the removal of the entire uterus in 1813, though Struvé in 1803 performed a hysterectomy and used ligatures. From Sauter, in 1822, we have the history of his method. He used no anæsthesia, no forceps to draw down the uterus, and had only an assistant to steady the organ by placing his hand on the abdomen. He separated the uterus without seeing the operative field, and used no clamp or ligatures for controlling the hemorrhage. A method so crude as this could not win favor among co-workers either by the method of its performance or its success.

The operation languished with but few improvements for the next thirty-two years, the only marked advance being made by Recamier, who in 1829 stopped the hemorrhage by ligatures and stitching. In 1854 Reicher brought forward his method. His great advantage was the drawing of

the uterus down by forceps, thus bringing into view the diseased tissues for the surgical work. He advocated the total removal of the uterus under chloroform.

In 1878 Freund of Strasburg formulated a modern technique for vaginal hysterectomy, and practically demonstrated it by total removal for carcinoma. Péan and his followers, Ségond, Bouilly, Terrier, and Doyen, perfected the technique by the use of the clamp, and extended its field of usefulness to the removal of fibroids and diseases of the appendages. The German operators, with the exception of Landau of Berlin, followed the use of the ligatures. There is nothing distinctive about the present German hysterectomy, except its slow and cumbrous character. In the fear of hemorrhage each incision, be it in vaginal, uterine, or peritoneal tissue, is followed by stitching, so that at times it becomes almost impossible to draw down the pelvic contents owing to the mass of suturing around the uterus.

I quote Péan's method as an early type of modern operative procedure. The operation as published in 1890 consists of the following steps: The patient being chloroformed is placed in the left lateral decubitus, the right leg folded at a right angle to the chest, the left elongated. Assistants on both sides retract with four flat blades the walls of the vagina. The operator seizes the lips of the cervix and draws it into view. The cervix is then dissected throughout its length, and any bleeding vessel that may be met is clamped. Immediately after the separation the peritoneal *cul-de-sacs* are opened. The specula are introduced deeper to enlarge the field of operation. The clamping of the broad ligaments is then undertaken, first by placing on one of the ligaments two or three forceps with blades curved or straight, taking care to cut all the parts clamped before applying a new forceps. The cut is made as near as possible to the uterine tissue. After one ligament has been divided the same process is repeated on the other side. If

it is impossible to remove the organ in a single piece, he practices morcellement, always proceeding with the progressive sections after preventive clamping of the broad ligaments. The removal of the uterus is followed by the excisions of the tube and ovaries when it is considered advisable. Ségond has modified Péan's method in several particulars. First he places the patient in the sacra-dorsal position, instead of Sims'; secondly, he has modified the classical circular incision around the cervix by adding to it two lateral incisions parallel to the base of the broad ligaments; thirdly, he divides the cervix into an anterior and posterior flap and removes them; then fourthly, if the uterus will not descend with an anterior hemisection he performs his central conical hollowing or removal of successive cones of uterine tissue until the uterus is small enough to be delivered; and fifthly, except in the case of the uterine arteries, the use of the clamp is consecutive instead of preventive, as Péan has always used them.

In 1882 Muller proposed the vertical division of the uterus into two symmetrical halves, and then ligating the two broad ligaments. In 1892 M. Queine revived Muller's method, which had been abandoned, and modified it into a method of his own. After the usual vaginal incision and separation of the vaginal tissue, he clamps the inferior portion of the broad ligament, and then proceeds to the progressive separation of the uterus from the anterior and posterior surrounding tissue, and then makes the vertical incision until the uterus is divided into two lateral halves, followed by clamping of the remainder of the broad ligaments.

In 1892 Doyen gave for the first time a description of his ingenious hemisection of the anterior wall of the uterus, the deliverance of the uterus outside the vulva, followed by the clamping of the entire broad ligament by clamps applied from above downward, followed by the removal of the uterus and annexa.

Such, in brief, are the improved methods of the present time. Let us see wherein they can be improved, point by point, thereby still further increasing their usefulness. The operation of vaginal hysterectomy is one above all others that becomes easier in the hands of a skillful operator by repeated performance. It differs from a surface operation on the human body inasmuch as certain portions of the field of operation are hidden from view, and the operator must aim, not only by the most favorable position he can place the patient, but by skillful manipulation of the specula, and of the tissues to be operated upon, to bring the pelvic contents close to the vulva, and within sight.

The vaginal canal is the natural outlet for the delivery of what is within the pelvis, and it is by close observance of the mechanics governing the passage of the fetal head through the maternal parts that we may improve our methods in the deliverance of growths and enlarged uteri through the vaginal canal. This canal, particularly that portion beginning at the outlet of the bony pelvis and ending at the vulvar orifice, is capable of extreme distention, sufficient as we know to allow the passage during parturition of a fetal head, provided the force is exerted in the right direction. These facts should not be lost sight of in our artificial manipulations.

*Position of the Patient.*—The patient must be so placed for the operation that the cervix descends to the lowest possible point in the pelvis, that is, the nearest to the fourchette or vulva. This is accomplished by placing the patient in the dorso-sacral position with the limbs abducted, the thighs strongly flexed upon the abdomen, and legs flexed upon the thighs, and sustained by upright rods attached to the end of the table. The buttocks of the patient should be brought well beyond the edge of the table, and maintained in position by Jacobs' buttock rest. This is an admirable device, inasmuch as the patient is maintained in the originally placed position and is not

changed during the necessary traction upon the pelvic contents, otherwise there is apt to be a change of posture during the operation, much to the annoyance of the operator. The height of the patient should be such in relation to the operator that the field of operation is about on a level with his chest, and easily accessible to his hand.

*Specula.*—The purposes of the specula are to bring the cervix into view and to enlarge to its greatest extent the field of operation. The fault of the specula now in use is that the blades are too long and too wide. Instead of permitting the cervix to be drawn down, by their length they push the uterus back, at the same time that the operator is making traction upon the cervix endeavoring to draw it down. In the same manner, by their width they fill up the vulvar orifice so that it is almost impossible to work in the vagina.

Anatomically we know that the average length of the vagina is  $7\frac{1}{2}$  cm. In the dorso-sacral position the canal is much shortened, and the cervix descends close to the vulva. Each case is peculiar to itself, not only due to individual differences, but also by reason of the amount of adipose tissue and the tonicity of the muscular fiber. To practically demonstrate the distance of the cervix from the vulva, I selected five patients at the clinic and placed them in the dorso-sacral position. In all the perineal body was intact.

CASE I. Was a nullipara, the uterus was freely movable. On separating the anterior and posterior vaginal walls, the cervix, on being seized with double tenacula, was drawn to the vulva without the patient experiencing pain.

CASE II. A nullipara, uterus somewhat fixed by pelvic adhesions, cervix elongated. Cervix could be drawn to within  $2\frac{1}{2}$  cm. of the vulva without the patient experiencing pain.

CASE III. A nullipara, uterus absolutely fixed by repeated

attacks of pelvic peritonitis; gentle traction brought the cervix to within 3 cm. of the vulva.

CASE IV. Multipara, uterus fixed by adhesions peritoneal and vaginal, subinvolution of uterus, laceration of cervix. Cervix drawn down to within 2 cm. of vulva without patient experiencing pain.

CASE V. Multipara, past the menopause. Relaxed vaginal walls; cervix could be readily drawn outside the vulva.

These cases taken at random from the clinic demonstrate not only the great mobility of the uterus and vaginal tissues, but also that the cervix in the dorso-sacral position lies close, or can be drawn close, to the vulva. In accordance with these anatomical facts, I have had hysterectomy specula made, none of them over 7 cm. long nor 4 cm. wide. Four blades are for ordinary work, and consist of a superior and an inferior blade and two lateral blades. The superior is 6 cm. long and 4 cm. wide, with convex surface, so as to protect urethra in making pressure upward. The inferior is 7 cm. long and 4 cm. wide, and concave in conformity with the disposition of the distensile tissues of the perineal body. The lateral blades are 7 cm. long and 3 cm. wide, flat, with rounded ends. Besides these four blades there is a fifth or long superior blade, similar in shape to the superior speculum for ordinary work, except that it is much longer, and the blade is bent at an angle of 70° to the handle.

It is used in exceptional cases, when by reason of dissection high up on the anterior uterine wall, it is necessary to pass the blade deeply into the pelvis and lift the bladder and ureters well away from the field of operation.

It is exceptional that all four blades are used at once. The inferior blade renders most efficient service owing to the deficiency of the bony framework posteriorly and the great distensibility of the soft parts. Laterally comparatively little space is gained by traction upon the lateral

specula, owing to the fixity of the rami of the pubes and ischium. Superiorly the fixed pubic arch presents the same objection. The best manipulation is often achieved by good traction being made upon the inferior speculum, thereby gaining the longest antero-posterior diameter possible, and then moving a lateral or superior speculum from place to place, according to the region upon which the operator is at work.

The steps of my method may be divided as follows:

1. Vaginal incision.
2. Separation of the uterus from the vaginal attachments.
3. Peritoneal incisions anteriorly and posteriorly followed by the separation of peritoneal adhesions if existing.
4. Delivery of uterus and appendages at the vulva after hemisection of the uterus.
5. Ligation of arteries.
6. Removal of uterus and appendages.
7. Suturing and partial or complete closure of wound.

1. *Vaginal Incision.*—The vaginal incision most favorable for subsequent work is the classical circular incision made with the scalpel, and the two lateral incisions 2 cm. in length, parallel to the base of the broad ligaments as proposed by Ségond. The advantages of these lateral cuts are that they not only give a larger vaginal opening for the passage of the uterus, but also that there is less danger of injuring the uterus.

2. The next step is the separation of the uterus from its vaginal attachments by blunt dissection. This must be done thoroughly, laterally as well as anteriorly and posteriorly, so as to free the uterus entirely from vaginal tissue.

3. Then the incising of the anterior and posterior peritoneal *cul-de-sac* is done by blunt pointed scissors, and the incisions are extended laterally out as far as the broad ligaments on each side. Upon the thoroughness of these first steps depends largely the ease with which the succeeding manipulations are accomplished. During this time

there is no danger of hemorrhage, provided we bear in mind the anatomical relation of the uterine arteries to the base of the broad ligaments and to the uterus, and care is exercised not to incise them. The bleeding from the small vaginal and uterine branches will cease without interference. The great mistake of many operators at this stage is the application of forceps to every bleeding point, thereby filling the vagina with clamps and blocking the way for further work. Every cubic centimeter of space is of the utmost value, and the useless clamping of small arteries is much to be depreciated.

It is now easy with the *cul-de-sac* well opened up to make a digital examination of the anterior or posterior surfaces of the broad ligaments as well of the uterus itself, and separate any adhesions that may be found.

4. The technique thus far is the same for all cases. The uterus is now free, not only from the vaginal attachments but also from its anterior and posterior peritoneal folds. The manner of delivering the uterus will vary according to the pathological lesion present. If the uterus is small, it may be grasped on its anterior surface by strong Museux forceps and drawn down and delivered outside the vulva. These simple cases are rare, however. In those lesions of the pelvis so grave as to necessitate a vaginal hysterectomy, the uterus is found to be enlarged by inflammatory products or growths or fixed by pelvic exudates. In these cases the best method is to reduce the size of the uterus by splitting it in the median line into two lateral halves, and incising from the cervix until the fundus is reached, both anterior and posterior walls. This is best accomplished by grasping the uterus by forceps on each side of the vertical section and drawing it into view for the cut of the scissors, and so on by successive steps until both walls are severed, always using care to draw down each part before cutting. In case of fibroids it may be still further necessary to cut out sections before being able to deliver the two lateral halves.



If this is conducted in the median line, there is no danger of hemorrhage. The lateral splitting of the uterus can be done without fear of hemorrhage, if care is exercised to cut in the median line. It is in this part of the uterus that there are no blood vessels of any size, and traction upon each lateral half will prevent bleeding. The two lateral halves are now outside the vulva held by traction forceps, the appendages, if free, have followed them; if not, the posterior surface of the broad ligaments can be inspected and the tubes and ovaries can be released from their adhesions.

5. The next step is the ligation of the arteries. In my last year's report of twelve successful fibroid operations, I said, "that in the evolution of the operation of morcellement clamping would be given up for a better method." Though the use of clamps was successful in my hands, so far as the success of the operation and the recovery of the patient were involved, still I was not satisfied with a method that required not only a self-retaining catheter for several days, and also produced excessive pain for the patient for thirty-six to forty-eight hours, but more than all whose recovery was characterized by sloughing of the tissues that had been clamped and by foul vaginal discharges. The method was unsurgical and unclean and not in keeping with our modern clear-cut methods. To overcome this objection I first contrived the specula, and exercised more thoroughness in the incisions and separations to gain a larger operative field in which we would be able to see how and where to ligate. Then I devised a ligature carrier, having a blunt, curved, and movable needle that could carry a ligature far out into the broad ligament without danger of injuring the intestines or important organs in the vicinity. When we consider that in each broad ligament we have only two arteries—the ovarian coming from the aorta and the uterine from the internal iliac—the use of the ponderous clamps of Péan and Doyen seem inexcusable. My method is, while the lateral halves are outside the vulva, to

pass a cat-gut ligature, by means of my pedicle needle, through the infundibule pelvic ligament of the left side and tie it. I have thus secured the ovarian artery and all its branches by one ligature. The next step is to secure the uterine artery on the same side. In tying the ovarian artery, if the broad ligament is grasped between the thumb and finger of the left hand, while the assistant makes traction upon the uterine segment outside the vulva, there is no danger of including any important structure in the ligature. With the uterine artery we must remember that the ureter passes under and behind the uterine artery only 2 cm. from the cervix when the uterus is in the normal position, consequently, though the ovarian artery is tied far out in the broad ligament, the uterine artery must be tied close to the uterus, only allowing space enough between the ligature and the uterus for a good stump so that there will be no danger of slipping of the ligature.

6. The uterus and appendages of the left side are then removed by blunt scissors, after having the superior and inferior margins of the broad ligaments caught by forceps to prevent their receding and to hold them in position while running catgut stitches are quickly taken along the cut edges, so as to leave no raw surfaces within the pelvis for intestinal adhesions. The right ovarian and uterine arteries are then ligated, the right half of the uterus and appendages removed, and the stump of the broad ligament stitched.

7. As to the closure of the vaginal wound and drainage, it depends upon the lesion that has existed within the pelvis what method should be employed. If pus has been found in the pelvis, many adhesions have existed, or there has been much unavoidable manipulation of the peritoneum, it is advisable to only partially stitch the vaginal opening with catgut, leaving a good central opening for drainage, into which a strip of gauze is introduced to facilitate the removal of fluids from within the pelvis. In all other cases the vaginal wound may be completely closed, the vagina lightly packed with gauze, and the operation is finished.

The asepsis of the operation may be thoroughly maintained by exercising care not to bring to the field of operation any bacterial organisms. The recent investigations of Drs. Menge and Krönig in Professor Zweifel's clinic have demonstrated that the cervical and uterine secretions are germ free, as is also the vagina, unless bacteria are introduced from without.

Hence our greatest care must be exercised in the external cleansing of the patient, the sterilization of the gauzes, instruments, and surroundings, as well as ourselves, and most of all, the catgut ligatures that are placed within the pelvis.

The ideal method of sterilizing catgut has at last been reached by Frogner in Paris, who sterilizes the catgut in the vapor of alcohol, and then hermetically seals it in tubes of bouillon. The slightest clouding of the culture at any time will be evidence of the presence of bacteria.

The advantages of this method are :

1. By the use of the modified specula greater thoroughness and ease in operating.
2. Greater certainty of removing all diseased tissue from the pelvis.
3. No raw surfaces or clamps left in the pelvis.
4. No necessity of self-retaining catheter with almost certain bladder irritation after.
5. Much less pain in the convalescence for the patient.
6. The convalescence is more rapid and with no sloughing and foul discharge; and on the whole, cleaner and more surgical throughout.

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## ENDOMETRITIS.

BY P. J. MONTGOMERY, M. D.

**T**O say that a woman has womb disease, or "female weakness," is no longer satisfactory to the patient, much less the physician. "To know the disease is half the cure." That is, the physician who is able to make a correct diagnosis of the disease he is called upon to treat has done half his duty to the patient and to himself.

To prescribe for a patient because she says she has a leucorrhœa, without using all proper means to find out the specific character of the discharge, would be, in some cases, criminal neglect. For how can she or the physician tell whether she has gonorrhea, vaginal catarrh, ulceration of the cervix, subinvolution, uterine displacement, granular degeneration, fibroids or polypi, disease of the fallopian tubes, or endometritis, without seeing the discharge and finding out its source?

No disease or symptom in the whole list of female ills is so common, so simple, and yet so grave. It will thus be seen that the disorder may in some instances be a trivial matter, which by a judicious combination of general and local means will soon disappear, while in many others it is an attendant circumstance of some grave pathological state of the uterus or vagina, and consequently difficult to cure.

This will depend greatly on the cause. If this can be readily removed the prognosis will be favorable. One great cause of leucorrhœa is endometritis. Frequently this is the symptom that drives the patient to the physician. Endometritis is an inflammation of the uterine cavity. It may be acute or chronic, it may affect the cervic body or the entire endometrium. It is frequently caused by the improper use of the uterine sound, intra-uterine pessaries, and intra-uterine injections, abortions, gonorrhea and suppression of the menses from cold, or the rash in eruptive fevers.

If there is present a scrofulous diathesis, anæmia, or obstructed circulation from mode of dress, or disease, the prognosis is more unfavorable. Marked exciting causes of this disease is laceration of the cervix and prevention of conception. The symptoms are not generally severe except from parturition. There is a sense of weight, dragging, and pain in the pelvis, and frequently pain in the back and thighs and painful micturition. After a few days there is a leucorrhœal discharge, which may be sufficiently irritating to excite vaginitis and excoriate the external genitals. At this stage she seeks advice from friend, advertisement, or physician.

In the early stage the mobility of the uterus, the absence of inflammation in the surrounding tissues, and the lack of marked constitutional symptoms will distinguish this condition from other diseases.

Physical examination shows the cervix enlarged and sensitive. There is usually more or less erosion about the os; the lips of the cervix show a rough, raw appearance. Where the cervix is lacerated the follicles are swollen, and chalk-like concretions are seen, giving a raspberry appearance to the cervix.

Sometimes the cervix will seem almost normal in appearance, and there is nothing but the excessive amount of tenacious cervical mucus to mark the presence of the disease.

In the chronic form the cervix suffers most, forming cervical endometritis.

In corporeal endometritis the leucorrhœa is less tenacious and viscid than when it comes from the cervix, and is often tinged with blood.

Hemorrhage is often present, hence the disease has frequently been called cancer. Examinations with the uterine sound in this disease should be made with the utmost caution, for the irritated and inflamed membrane bleeds easily, and is very sensitive.

Endometritis may be a dangerous or fatal disease when long neglected or badly treated. The inflammation may extend to the fallopian tubes, and when arising from specific puerperal causes involve the peritoneum in serious suppurative inflammation.

The chronic form is one of the most common of the diseases that come under the care of the gynecologist, and when associated with ovarian inflammation, the most difficult to cure. Great care should be used in the diagnosis, so as not to mistake a case of acute endometritis for the chronic form. The same treatment will not do for both forms of the disease. Endometritis is almost invariably a disease of married women. Therefore it usually depends on, or has some connection with, marital rights or the process of parturition.

Lawson Tait says that acute endometritis is nearly always a result of gonorrheal infection.

I have seen and treated several cases of gonorrheal endometritis, but my experience leads me to believe such cases are few and far between.

The pathology of endometritis is similar to inflammation of mucous membranes elsewhere, with the addition of inflammation of the Nabothian glands. The causes of this disease are very like those producing catarrhal inflammation in other parts of the body, and the same *general* principles apply to both.

*Treatment.*—First remove the cause, if possible. In the acute form rest in bed, aided by the use of aconite, belladonna, cimicifuga, pulsatilla, sepia, secale, tartar emetic, nux vomica, verat. v., etc.; will be followed by speedy relief and cure; intra-uterine medication by means of cotton sponges saturated with belladonna, opium, and glycerine will bring great relief of the pain and hasten the cure.

In cases complicated with corporal metritis from sub-involution, we must resort to depletion by puncturing the

cervix, the introduction into the vagina of cotton tampons saturated with pure glycerine, and hot water injections.

If the endometritis is dependent on laceration of the cervix, and eversion is the result, nothing but a surgical operation will promise a permanent cure.

The treatment of chronic endometritis by such prominent gynecologists as Ludlum, Thomas, Emmet, Churchill, Lawson Tait, Marion Sims, and E. H. Pratt, suggests a great variety of methods: the curette, nitrate of silver, iodine, hydrastis, carbolic acid, calendula, hamamelis, glycerine, etc.

In relating my own method of treating endometritis, I will state that I prefer the curette, carbolic acid, iodine, glycerine. First dilate the cervix and thoroughly curette; then apply to the endometrium, by means of cotton on a flexible probe, tr. iodine 2, glycerine 4, carbolic acid 1; immediately wash out the uterus with hot water. Great care should be observed to avoid touching the healthy mucous membrane with the solution. If the endometritis is the result of subinvolution, pack the uterus with iodoform gauze after curetting. This method has given the best results. I have used electricity in many cases in the last twenty years, and prefer it to all other methods in certain cases. When there are congestion and exhausting hemorrhages, place the negative pole on the sacrum and the positive in the uterine cavity, or sweep the endometrium with the uterine sound at the end of the positive sound.

I wish to add here that sepia 6x has been the most helpful remedy in clearing up a case of chronic endometritis that has come to my notice.

## A CASE OF PUERPERAL ALBUMINURIA.\*

BY ELIZABETH JARRETT, M. D.

MRS. E., Swede, age twenty-eight, married three years, consulted me first in the spring of 1895 for a troublesome pruritus of the lower extremities, due to pregnancy, then advanced some three or four months; a slight œdema of the lower extremities and a stiffness of the hands led to an examination of the urine, which was found to be normal in S. G. and without albumin. The continuation of her symptoms in spite of treatment, added to the fact that just at this time a sister pregnant eight months was forcibly delivered during an attack of eclampsia, led me to keep a close watch on the urine.

Up to March 1, *i. e.*, to the beginning of the fifth month of gestation, the condition of the urine was normal. The itching was relieved, but the hands and feet were still œdematous. The œdema had also extended to the face, which was of a peculiar waxy appearance. For one month the patient neglected to present herself. April 1 an examination of the urine gave a S. G. of 1014, and a startling amount of albumin. The patient was in much poorer condition. The lower extremities were immensely swollen, nausea and vomiting had returned, and the itching was intense.

In April I asked Dr. Danforth to see the patient with me, and discuss the advisability of a forced delivery. He did so, but decided to wait as long after the seventh month as possible to insure the viability of the child. The urine at this time varied from 1 pint to 1½ quart, albumin three-tenths to one-half per cent. in quantity; urea fifteen-seventeenths gram.

April 28 the patient miscarried, after a short labor. The pregnancy was seven months, one week advanced,

\* Read before the New York State Homeopathic Medical Society.



according to her own reckoning. The child, a boy, had been dead several days.

The urine rapidly increased in quantity, the œdema disappeared less rapidly, and albumin persisted for perhaps six weeks, then disappeared entirely. On the fourth day after delivery the patient developed an extensive papular eruption, intensely irritable in character, mainly on the abdomen and legs. This slowly disappeared, to be followed by a similar vesicular outbreak on the hands, feet, and entire body, even to the face. This was followed by a less extensive pustular eruption.

For some time I lost sight of the patient, she having declared herself quite well.

In December, 1895, the patient conceived again. The same set of symptoms presented themselves as in the first pregnancy, but earlier in point of time. For a while they were more amenable to treatment, probably because I knew my patient better. Albumin appeared much earlier and increased rapidly in amount. The legs and abdomen were as œdematous at the fourth month as they had been at the seventh month of the first pregnancy.

April 18 the patient developed uræmic symptoms. Inability to retain food, headache, dim vision with spots before the eyes, and intense pain in the epigastrium. She breathed with the greatest difficulty, and examination discovered fine râles in the lower posterior lobes of both lungs. Dr. Wait, who was called hastily into consultation, advised waiting for a day or two. The urine during this attack presented evidence of serious trouble in the kidneys. Pus, blood, kidney epithelia, and casts were present, besides a large per cent. of albumin. Remembering the rapid subsidence of the symptoms after the first miscarriage, I decided to wait no longer, but to bring on labor at once. She was now only  $4\frac{1}{2}$  months advanced, yet her symptoms were more alarming than they had been at any time during her first pregnancy.

April 21, just one year after her first miscarriage, she was forcibly delivered of the dead fetus, small and very poorly nourished. The placenta had undergone partial fatty degeneration. The patient stood the operation unusually well. The œdema began to disappear immediately, but more slowly than after the first labor; but there was, this time, no cutaneous outbreak. The patient was up on the tenth day and out in a few weeks, declaring she felt better than at any time since her marriage.

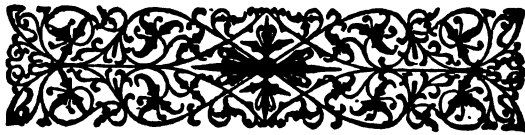
Curiously enough the sister who had been delivered during an eclamptic attack the year before, miscarried at about six months this spring. The particulars of her case are not in my hands.

A careful watch has of course been kept on the conditions of the kidneys. All evidences of acute nephritis disappeared shortly after delivery. The patient now presents evidences of chronic catarrhal trouble. Albumin at present is less than one-twentieth per cent. Dr. W. I. Pierce kindly verified my examination of the urine.

This case is narrated to bring out one point only. All cases of puerperal albuminuria are necessarily watched with suspicion. Undoubtedly many of them pass through the trial without developing eclampsia, and without any serious imprint of damage being left upon the kidneys. To say, therefore, that the course pursued should in all cases be conservative and the pregnancy allowed to continue in the hope that the child may attain viability, is fallacious. Such cases should be regarded not from the standpoint of present safety, but with a view to the entire future welfare of the mother. The continuance of the albumin for so long a period after the discharge of the fetus in the first pregnancy showed, that perhaps while no serious damage had resulted to the kidney structure, the trouble was not entirely functional. When, therefore, increasingly alarming symptoms occurred and at a correspondingly earlier date in the second, combined with the

appearance of new elements of danger in the urine, there is no question in my mind that the course pursued was the right one, and that just so much of strain was removed from the kidneys by the induction of labor at so early a date. Each case must be judged on its own merits. This patient might have struggled on to six or seven months and miscarried as before, but there is no question that the kidneys would have been left in a far more crippled condition than they are now, provided the patient had survived. The fact that they resumed work immediately and that there was absolutely no cutaneous outbreak justifies this belief.

What course should be pursued in the event of another conception? In all probability symptoms would again anticipate and earlier interference than before become necessary.



## UTERINE MASSAGE IN ANTEFLEXION—CLINICAL CASE.

BY M. BELLE BROWN, M. D.

THE interest in this special case hinges on the curability of what was considered an incurable condition except by surgical methods—besides being my first and only case of pelvic massage.

Mrs. M., age twenty-eight—married eight years and never pregnant. Her menstrual history is as follows: First appearance of menstruation was at eleven years of age and accompanied by great pain. She continued regular from the first, but never remembers being free from pain at the time of the flow. She was always a delicate child and suffered from stomach disorders and general nervousness. She lived in the country, and all her symptoms were attributed to that hydra-headed monster *malaria*. In accordance with orthodox medicine she was dosed galore with Warburg's tincture and quinine. One week out of every four she was unable to leave her bed, and the whole household, along with the kindly disposed neighbors, were kept busy in their efforts to relieve her pelvic pain together with the nausea and vomiting. As time went on she grew excessively nervous, anæmic, was badly nourished, and suffered from spinal irritation and insomnia. The friends were all in sympathy with this "poor sick girl." Strange to say, at twenty years of age she married. She gradually grew worse and spent nearly twenty-four hours a day in bed. Existence had become so painful and weary to her that she finally submitted to an examination of her pelvic organs. Unfortunately the examination was either carelessly made or made by someone not familiar with uterine pathology, for *no* pelvic trouble was found to account for either her dysmenorrhea or sterility, and she was again put through an anti-malarial treatment. After a few more years of

added misery, and eight years after marriage, it was my privilege to examine her. From her symptoms of vesical tenesmus (this alone made her life a burden), hysteria, neuralgia, and dysmenorrhea, ante flexion of the uterus was suspected. The examination confirmed the suspicion—the cervix was bent forward and upward and the fundus rested low down in the anterior fornix, making a deep sulcus between the cervix and the body. The diagnosis was an exaggerated third degree of ante flexion, perhaps congenital. The flexion was irreducible with tenaculum hooked into the cervix, and with pressure upward externally on the fundus I could not straighten it. It may not be a matter of much interest, but by the time the examination was completed the patient was in hysterics and vomiting. The flexion was the worst I have ever seen, and accompanied by all the local and reflex symptoms attendant upon this malposition.

“Could I cure her?” was naturally her first question. I promised nothing, but explained the various methods of treatment in such conditions, viz,—rapid dilatation, discission of the cervix, amputation of the vaginal portion of the cervix, galvanism, and pelvic massage,—all with a view to her becoming pregnant, which would, I thought, complete the cure. She refused to submit to any of these methods, and, after another period of waiting and suffering, sought advice elsewhere. This time she was given no choice of treatment, an amputation of the cervix was insisted upon as the only means of cure, the opinion of this physician being that the cicatricial tissue in the angle of the bend was too firm to yield to any softening process. When she found she would be obliged to take an anæsthetic to have this operation done she returned to me, saying she had decided to try the local massage. Now it was my turn to be discouraged; I was sorry I had mentioned anything about massage, for I regarded it as less useful than any of the other methods and had never tried it, besides not being overstocked with

faith in it. However, we agreed to try it, and commenced at once.

The method used was by two fingers of the right hand in the vagina pulling the cervix backward, with the left hand on the abdomen pressing the fundus upward, and rotating it in order to stretch the contracted tissue. The anterior fornix was then stroked laterally and from above downward. This process occupied ten or fifteen minutes when a tampon, moistened with ichthyol and glycerine, ten per cent., or one of boroglyceride, fifty per cent., was placed in the sulcus between the body and the cervix. This treatment was followed once or twice a week for a period of eight months. The menstrual pain grew less severe as the tissue softened and as I was finally able to bring the cervix in line with the axis of the vagina. Laminaria tents were now used to render the cervix patulous, and later the blades of a steel dilator were inserted into the cervical canal as far as the internal os, and the canal dilated to the extent of half an inch. This was done the last day of her menstruation, and she was instructed not to come to the office again until after her next period. In five weeks she reported, saying, "for the first time in her life she had gone one week over her time." She was having so much pain and pelvic discomfort that I feared she would miscarry if she was pregnant, and I gave her  $\frac{1}{4}$  grain dose of opium in the office and kept her until the pain was less, when I had her go immediately home and go to bed and stay there. She appreciated the importance of keeping quiet, and for once she was willing to do as directed. Her pregnancy was the object for which we were working to complete the cure, and anteflexion of the uterus being one of the recognized causes of abortion, it was only time lost giving her the homeopathic remedies I had so often given for her dysmenorrhea without benefit, that I considered *opium* was *the* indicated remedy. It was necessary that the pain be controlled or the irritation would

set up contractions of the uterus and she would abort. The pain in these cases is due to the stretching of the rigid tissue of the distention by the gravid uterus, and I know of no remedy homeopathic to this condition, therefore, THE remedy is the one that we know *will* lessen the pain. During five months of her gestation she had a most uncomfortable time. She received from  $\frac{1}{4}$  to 1 grain of opium daily. During the sixth month her pain was less and she only had occasional doses of  $\frac{1}{4}$  to  $\frac{1}{2}$  grain. From the seventh month on she was entirely free from pain. She was kept in bed during the five months in which she had the pain, but more on account of her nausea, which was relieved when lying on her back. It was curious to observe how soon her nausea would come on when she would assume an upright position. I presume the reason of this was the uterus was inclined to resume its old position, and the pressure caused the reflex nausea just the same as when the nerve terminals were pinched in the flexion. Dr. Barnes states "that in obstinate sickness the uterus has been found locked in the pelvis." Whether the nausea, which is considered "part and parcel of pregnancy," is due to the undue stretching of the uterine fibers or proceeds from actual compression of nervous structure, both these causes are present in a marked degree in ante-flexion. May not the "morning sickness" that pregnant women so often have be due to a sinking down of the uterus as the patient stands on her feet after rising? It has been a matter of clinical experience that nausea in these cases has been lessened if the uterus was kept well supported by tampons of wool or by a pessary. After the sixth month and with an abdominal bandage fitted, Mrs. M. was allowed to go about and take outdoor exercise. She went to time—had a difficult labor, but made a good recovery; in fact was too well cured, for she got up with a retroverted uterus. This malposition was brought about by keeping her too constantly on her back during the lying-in period

of four weeks. This faulty position was soon corrected, however, and three years have now elapsed since her confinement and she still remains in perfect health. None of the old symptoms, either local or remote, has recurred. I shall be just as well contented if I am never again called upon to conduct another patient through such a trying gestation.

The points I wish to bring out in reciting so minutely the details of this case are the following:

1st. Ante flexion of the uterus, with its accompanying dysmenorrhea and sterility, can be cured by pelvic massage.

2d. Abortion in ante flexion can be prevented by the use of opium to control the pain which is always present, in greater or less degree, during the early months of gestation.

3d. Reflex nausea, due to an ante flexed and pregnant uterus, can be relieved by the recumbent position.

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## A CLINICAL STUDY IN THE USE OF THE CURETTE.\*

BY WM. CASH REED, M. D.

I DO not propose to enter upon a general dissertation on the subject of curetting the uterus, but will plunge at once *in medias res*, and try to put before you a few clinical pictures which will, I trust, serve to show the utility of this form of surgical treatment in suitable cases of uterine disease.

Let me observe, however, first of all, that in speaking of curetting, I do not refer to any partial, or even slight measures, but to a definite surgical procedure, requiring in all cases an anæsthetic; to one, moreover, which necessitates preliminary local treatment; and, in fine, to one which involves certain definite surgical risks. Curetting, then, in this sense, is not a *minor* surgical operation.

With regard to details thus briefly hinted at, I think

\* Presented to the Section of Gynecology of British Homeopathic Society.



they will be sufficiently discussed in the course of my remarks to obviate at this stage any preamble upon this head.

In glancing at the literature of our subject one is struck by its paucity, and, in looking for definition in what does exist, by the haziness which characterizes it, especially in reference to the *class* of cases which are suitable for this treatment. This is to be deplored because it threatens to consign a most valuable method of treatment to the limbo of oblivion, a goal which is often reached, perhaps justly, by some of those meteoric flashes which for a brief space illumine the medical world! The cases cited are, I think, sufficiently varied in their characteristics to indicate a wide range of those suitable for curetting. A word is necessary as to the operation itself. I am struck by the extent to which the preliminary dilatation is sometimes carried, and of the almost vicious amount of scraping done by some operators. Although I am open to correction on this point, so far, I can hardly bring myself to believe that the first is essential, or that the second is desirable. May it not be taken as an axiom applicable to all surgery, that it is one's duty, *not to show how much can be done with safety, but how little need be done with efficiency?*

The first case to which I will refer is one of

CASE I.—Chronic ovarialgia and dysmenorrhea, associated with cervical endometritis and probably tuberculous disease of ovaries, much relieved as regards the ovarian pain by curetting. Miss A., aged twenty-five, has suffered from enlarged cervical glands for fifteen years. For the last two years she has complained of constant pain in the region of the ovaries, it is especially severe at the "periods," and she suffers considerably from leucorrhœa. On examination the uterus is found in the natural position, and not enlarged; the cervix is notched, and gives the impression of that of a multiparous uterus; there is great pain in both *culs de sac*, and on the examining finger being withdrawn it is found

copiously covered with muco-pus. Thus the case will be seen to offer a sufficiently unfavorable panorama of symptoms to make one hesitate as to what to do for the best. I will not here allude to the medicinal treatment which was, of course, directed to the tuberculous manifestations, but observe that in view of the fact that the impact of the tuberculous mischief was evidently chiefly upon the endometrium, and believing, moreover, that the ovaries were affected by direct anatomical continuity, I decided to curette. This was accordingly done, and as my notes record laconically shortly after, the patient was "much better," and later on that she has been "very much better." This was especially noted during a certain period of three months, in the course of the subsequent history, until indeed the sudden news of her father's death abroad prostrated her. It is significant to note that the improvement consisted in the alleviation of the pain in the ovaries, and that this pain, as is so constantly observed in the mobile nervous system of women, was set agoing once more on receipt of the distressing news.

There is one point which in all fairness must be stated, as it may be held by some to militate against the ultimate good of the surgical treatment this patient received. A long time afterward she told me that after the pain in the ovaries had ceased, she had, to use her own words, "thirteen abscesses in the neck." As bearing upon this, I may mention that she was contemplating marriage, to prevent which undesirable consummation I used all the arts of persuasion which I could bring to bear upon her, with what ultimate good I do not know, probably as much as and no more than is usual in such cases. Could I have my own way, I should now send her to reside on the wilds of Dartmoor, which is nature's most marvelous sanatorium in all such cases, as I have before mentioned as the result of much experience.

The next case I wish to bring before you is one of

CASE II.—Auto-infective endometritis at the menopause,

causing a rise of temperature every day toward evening—cured by curetting. Mrs. B., aged forty-seven, who is nursing her husband, a complete invalid from tachycardia, complains of various ill-defined symptoms, *e. g.*, flatulence, headache, languor, sleeplessness, etc., which may generically be called "*malaise*." Having regard to the time of life reached by this lady, and prosecuting inquiry on the lines thus suggested, I ascertained that the "period" was quite regular, though lessening in amount; that there was an acrid leucorrhœa; that the temperature in the after part of the day was 100° or over, especially at the "periods"; and that the headache referred to was much worse for a week or so before the advent of menstruation. Examination revealed a freely movable uterus, with the anterior lip of cervix purple and œdematous; a long slit was present in the cervix, with a second at right angles to it, and there was considerable ectropion. In view of the above symptoms, both subjective and objective, it appeared quite obvious that the endometrium required definite radical treatment. I therefore curetted this patient with great thoroughness, and, with the aid of the galvano-cautery, removed the redundant portions of the cervix. Pure carbolic acid was very freely applied inside the uterus by means of Playfair's probes, and the cavity stuffed with iodoform gauze for a period of sixty hours. In due course the gauze was withdrawn, and free antiseptic douching commenced. The recovery was steady and uneventful. One point, however, is worthy of record, *viz.*, that on the day after operation, the urine on heating threw down an enormous proportion of albumin, somewhat to my dismay, as I feared I might have overlooked a latent nephritis. Very shortly, and I may add suddenly, this entirely disappeared, showing that it was due to the nerve shock of the operation, aided and abetted doubtless by the prolonged strain of nursing previously alluded to. It was beautifully significant to note, from the date of operation, a cessation of the afternoon rise of tem-

perature, and the gradual return to health of the patient, one symptom after another yielding. Subsequently she returned to her home in Cornwall, and resumed to a great extent the nursing of her husband until his death, which took place many months after, and, as she expressed it, she was able to combat this strain with an amount of strength and ability which would doubtless have been impossible but for the curetting. She remains in good health at the present time.

CASE III.—Sub-involution with menorrhagia, adhesions between left appendages and uterus, in a lady, several years resident in India, cured by curetting.—Mrs. C., aged twenty-nine, has resided several years in Chittagong; she has had one child, now five years old, followed by a miscarriage three years afterward. When the child was born she was perforce subjected to the rough manipulations of a native midwife; and since this date she has had profuse menorrhagia, the catamenia occurring at intervals of fourteen to twenty-one days. Several attacks of malarial fever, leaving their too-evident traces, and hemorrhoids add to the category of woes. On examination the uterus is found less freely movable than normally would be the case; it is drawn over to the left side of the pelvis, and is apparently adherent to the ovary of same side. There is, in addition, a laceration of the cervix. In due course the piles were dealt with by the galvano-cautery, after forcible free dilatation of the anal aperture. It then became necessary, after the lapse of a fortnight or so, to undertake local treatment of the uterus. The patient was treated the while by various remedies, *inter alia* by nitric acid, from which especially she received benefit. In view of the long-standing mischief in the left side of the pelvis contiguous to the uterus itself, the signs of which were definite and tangible, and in view also of a possible, though less apparent, morbid condition of matters on the right side also—for she suffered much and continuous pain on this side, more so indeed than on

the left—I thought it desirable that the responsibility of treatment should be shared, and, accordingly, sent her to London to see Dr. Burford. He, confirming my diagnosis, advised, as preliminary treatment, that the left *cul-de-sac* should be well tamponed with boro-glyceride for four days before operation. This was accordingly done. I was the more desirous of a second opinion, because, as we all know, one of the details of the operation is the seizing of the uterus and drawing it down as far as is consistent with safety. To draw forcibly upon a uterus, which might not unlikely be adherent to a phlegmonous broad ligament on one or both sides, would be a perilous procedure, and one which is justly and freely condemned. The risk of rupture of some portion of the pelvic contents involved in the inflammatory mass goes without saying. Happily no such eventuality occurred in this case, and the patient has made an uninterruptedly good recovery. She is completely relieved of the severe periodic floodings, and of the pain also, with the exception of an occasional reminder on the right side if constipation exist, or there be any severe jarring of the pelvic contents, accidentally brought about from any cause.

CASE IV.—Carcinoma of cervix uteri, in a very advanced stage, with metrorrhagia and fetid leucorrhœa, treated with curetting and the application of chloride of zinc, after the method of Sims and Heywood Smith, with an arrest of hemorrhage and removal of fœtor.—Mrs. D., aged forty-five, came to the out-patient department of our hospital, complaining of pain in the sacral region, and of a continuous and offensive sanious discharge from the vagina, of considerable weakness, and of a falling off in her powers of sustained work. She was not haggard-looking or thin, but there was that indescribable something in the facial expression which one comes to associate with malignant invasion. She had been under treatment, but I think had not been examined, at all events the nature of her ailment

was quite unknown to herself or to her friends. On examination I found a large deep crater-like excavation involving the cervix and extending far into the corresponding *cul-de-sac* on the right side. Moreover, the uterus was to some extent fixed. There was a foul discharge emanating from the ulcer itself, and from the *débris* which was lying more or less detached in its cavity. I told the friends the case was probably beyond cure, and that so long as the disease remained unchecked, matters must go from bad to worse, and that the hemorrhage would probably continue. The patient, accordingly, being placed under an anæsthetic, I scraped the ulcer and the uterine cavity with the sharp curette, until all that was removable of the growth was taken away. There was a good deal of bleeding, and when this ceased, following the method of Drs. Marion Sims and Heywood Smith, I packed the crater with small pieces of absorbent wool, previously well soaked in a saturated solution of chloride of zinc, and dried. These were packed in very firmly, and so as to fill the cavity completely. Then an ordinary dry tampon was applied, being pressed well against the latter. Finally the vagina was packed with tampons soaked in a saturated solution of bicarbonate of soda. The following day the tampons only were removed, and free, but not forcible, antiseptic douching commenced through a Fergusson's speculum, passed well up to the cervix, or rather what was left of it. The zinc chloride packing was allowed to remain *in situ* for three days, when, presuming it had effected the object in view, viz., the destruction of the neoplasm, it was removed piecemeal. A good plan is to use a kind of serrated burr at the end of a rod to entangle the pieces of wool. At the end of ten days or so the slough came away by degrees, its detachment being promoted by the douching.

I am sorry to say that owing to carelessness the notes of this case were lost, so I can only rely upon memory for the sequel. *Much* that was satisfactory I did not expect, and

anything permanently curative could not be even hoped for, but as to the arrest of the bleeding, the measures employed proved efficient. Ultimately the patient succumbed at her own house, from disease in the neighboring structures, and which I have no doubt was present in an initial stage when we were first called upon to render aid. Of this I feel convinced, that cases in a less advanced stage may probably on these lines be permanently relieved, and, in a certain proportion, radically cured. When one remembers in what an exceedingly large proportion of cases the disease commences in the cervix, it stands to reason that this treatment ought to be effectual. How constantly, however, the nature of the disease fails of detection until it is too late to apply this, or even other more radical treatment, with any hope of success!

CASE V.—Menorrhagia, due to nodular fibroid condition of uterus in a single lady, cured by curetting.—Miss E., aged thirty-four, consulted me for headaches, chiefly in supra-orbital and occipital regions. She called them "sick headaches," and told me they were relieved by heat. I ascertained there was a history of rheumatic gout on the maternal side. She gradually improved under various remedies, but not so markedly as it seemed reasonable to expect, and it appeared as though there were something, hitherto hidden, barring the way to real recovery. On inquiring with more precision than hitherto about the menstrual function, I ascertained that the "periods" were excessive; and on pressing for more definite information on this point, I learned that it was necessary to change as many as twenty to twenty-four times altogether, "drenching" being indeed at times the only term applicable to the condition present. Moreover, for the first twenty-four hours pelvic pain was very intense. There was no noteworthy blanching of the ocular or buccal mucous membranes; the part, however, which had to bear the brunt of this exhausting discharge was evidently the cranial sensory nerves.

I determined to dilate the uterus, with the double object of ascertaining if any morbid growth existed, and also of giving relief to pain if possible by the forcible stretching of the structures of the cervix. This treatment brought to light no growth interiorly, but the bimanual examination, carried on concurrently, revealed an outline of the uterus which was neither so smooth nor so regular as would be consistent with a normal condition of that organ.

The dilatation was succeeded almost immediately by a hemorrhage, which pursued the type as to time and character usual in the case of this patient, though the catamenia had only just ceased. Subsequent "periods" proved less painful, though there was little or no diminution as regards the quantity. I, accordingly, decided upon curetting, which was done with the flushing curette, and the denuded surface was very freely painted afterward with pure carbolic acid. An iodoform gauze intra-uterine drain was employed, and the patient in the course of a week or so was able to get up. The next "period" was characterized by fourteen changes, and the next curiously enough was pretty much the same as regards quantity as before operation. Thereafter matters greatly improved, and have continued quite satisfactory, so that now there is no greater quantity than would make a so-called "moderate period."

In conclusion I ought to mention that in view of the utility of electricity in some cases such as this, I employed the continuous current at intervals, for some weeks, by means of an insulated terminal at the uterine os, and the other over the hypogastrium. No effect was, however, traceable to this treatment.

CASE VI.—Endometritis and salpingitis, probably specific in origin, accompanied by profuse metrorrhagia, with complete and permanent relief of latter by curetting; severe acute ovaritis when convalescence was nearly complete, owing to an error in a detail of nursing.—Mrs. F., aged thirty-five, has a fairly typical history, pointing to her ail-



ments as essentially "specific" in character. She has had four miscarriages, the last four years ago, since which she has been definitely ill—in fact, to use her own expression, she has "never seemed to get over it."

The periods occur every fortnight, and last a week; they are very profuse, necessitating fifteen or sixteen changes, and she suffers much from a sense of "bearing down" then. She is in constant pain in the epigastrium, and in both ovarian regions, and the lumbar spine aches. She has, moreover, the typical "tubal pains" in the neighborhood of the iliac crests. On examination, under an anæsthetic, there is revealed an exceedingly extensive tearing of the cervix, which involves the mucous membrane in each fornix; and both lips of the cervix, especially the anterior, are extensively hypertrophied. There is also a distinct fullness in the region of the right fallopian tube.

Curetting was, accordingly, undertaken and well borne, and convalescence was well maintained afterward, the temperature being normal throughout. She expressed herself subsequently as not having been so well for six or seven years as now. Ten days after the operation, with a view treating the cervical hypertrophy, tampons of ichthyol-glycerine were employed, and ichthyol-lanolin was freely applied externally over the hypogastrium and adjacent part. And now a most unfortunate incident occurred, which I record as a warning to myself and to all whom it may concern. The patient had of course been kept in bed, and one day the nurse in charge, with sadly misdirected zeal, instructed her to leave the ward for the purposes of nature. The day happened to be exceedingly cold. What happened? Exactly that which happens to many a woman, in degree, who undertakes a railway journey, *e. g.*, on a cold day and insufficiently protected, the catamenia being present, *viz.*, pelvic inflammation; in this case probably of the ovaries and tubes chiefly. Rigors supervened, the temperature rose to 103°, and the pulse was 120. Diarrhea was persistent

and intractable. The patient's husband now returned from abroad, and she left the hospital at her own desire, and with much apprehension on my part. For six weeks she was confined to bed, and her illness dragged on a wearisome course for much longer, the details of which I need not trouble you with. Finally, however, a rallying took place and she recovered. I saw her again after six or seven months, and found her attending in some measure to her household duties, though she is, of course, in a most unstable condition as regards a fresh outbreak of pelvic mischief. With reference to the condition for which she sought advice, the improvement is definite and marked, and, in her own view, at least, eminently satisfactory. It consists essentially in this, that the "period" is now scanty and regular, and the "bearing down" has entirely ceased. She is now under observation for the sequelæ of the pelvic inflammation, and it will, I think, be right to recommend oöphorectomy.

CASE VII.—Menorrhagia for twelve years, due, probably, to small fibroid, completely cured (and remaining so for two years) by curetting.—Mrs. G., aged twenty-seven, married a few years, no children, states that she had "inflammation of the womb" some years ago; that her "periods" are characterized by the necessity to change some eighteen or twenty times; that she is short of breath, and suffers much from throbbing headache. On examination I found the uterus irregular in shape, and nodular in outline, especially in the neighborhood of the right ovary. Taking this to be probably a fibroid enlargement I decided to curette. With Dr. Seelenmeyer's assistance this was done, and iodized phenol applied to the denuded interior of the uterus. She did exceedingly well, and the next "period" was characterized by an amelioration of her former troubles. I now lost sight of the patient for nearly two years, though I had no reason to suppose she was other than well. When I saw her a few weeks ago the anæmia had given place to a rosy appearance. She told me that the catamenial discharge

had diminished to an amount which might be represented as one-quarter or one-fifth of that before operation. The old symptoms were, as she put it, "all dying away," and she added that she felt "as well as any other woman." This was borne out by the fact that she had just been entertaining many of her friends, who were flocking into Plymouth at the time to the Devon Agricultural Show.

In conclusion, I ask you to take these cases for what they are worth, and let them speak for themselves. They are clinical facts from notes made at the time, and do not admit of romance in the history, and I trust their substance warrants the title of "clinical study."

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## ELECTRICITY IN OVARIAN DISEASE.

By J. K. EBERLE, M. D.

DECEMBER 15, 1894, I was called to see Miss Allie —, aged twenty-one, blonde, whom some six years previous I had attended through a severe attack of typhoid fever; which ran full three weeks. She convalesced slowly through the fall and winter, and with the coming of spring regained her normal health, with the exception of a neuralgic pain in the region of the left ovary during menstruation. The symptoms of the present attack—which was brought on by exposure while heated from dancing—were flushed face, fever, temperature 101°, whitish, coated tongue, severe pain in the left ovarian region, great tenderness, pain running into left crural nerve. Treatment, aconite 2x in water for the fever, alternated with cimicifuga rac., for the pain in crural nerve, woolen cloths rung out of hot water applied to the locality of the pain. Under this treatment the severity of the disease was controlled so that she was enabled to sleep, and rest quite easy while awake. About the fifth day from my first visit, and within a few days of her regular period, there was during the night a

discharge of pus streaked with blood from the vagina, after which all pain ceased and she fell into a sound sleep of some hours' duration. I now administered *hepar sul.*, and kept a watch over her for the next nine days, meeting the symptoms as they appeared with indicated remedies. She was doing so well that I discontinued my visits, but five days afterward, on the 4th of January, I was called again to find her suffering the same as at my first visit. At this visit I made a digital and specular examination, and found the womb normal, except somewhat congested, left ovary tender and somewhat enlarged. I gave the treatment to meet the indications as best I could, until another discharge of pus per vagina.

Here they requested counsel with an old-school physician, who diagnosed the condition as salpingitis or pyosalpinx, with possible involvement of the broad ligaments. He suggested a blister over the seat of the pain, hot water douches, and small doses of calomel with sodium bicarb. (I had left that school of treatment over twenty years and was not going back to it.) Before I made my next visit they notified me that they would make a change of doctors.

She remained under his treatment for four months, and when able to go about again was lame upon the left side. Shortly after this she came to my office for electrical treatment for the lameness. After a few treatments with the galvanic current "positive" to the lower spine and "negative" to the foot; all pain and soreness had gone and the lameness disappeared. At this time she would have at her monthly periods a black discharge from the vagina, so offensive they could hardly stay in her room. I treated her every other day for three weeks with the "positive" over the ovary and "negative" on the spine, from ten to fifteen minutes at each sitting. When her periods came on there was some improvement in color and odor. At this time I had put into my office a bath tub and used the sinusoidal current, which electrifies the water

without the electrodes touching the body. I gave her a bath every third or fourth day, using massage over the ovarian space while in the bath, keeping her in the bath from fifteen to twenty-five minutes. When her periods came on there was a slight odor and the color almost normal. The month following she averaged two baths a week, and when her periods came on the third month they were normal. She gained two pounds per week while taking the bath, and finally regained her normal health.

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## A VAGINAL HYSTERECTOMY, AND ITS SEQUEL.

BY GEORGE BURFORD, M. B.

**T**HE lady otherwise moderately well, was forty-nine years old, and her most marked symptoms were a constant though inconsiderable pinkish discharge, and a persistent backache.

I found a scirrhus mass involving the cervix uteri. As the uterus itself was mobile, and there was no evidence of infiltration into either broad ligament, I advised complete removal of the uterus, together with the diseased cervix, ere cancerous deposit in peri-uterine tissues should render all hope of entire ablation futile.

On June 13 I performed vaginal hysterectomy, under conditions of extreme difficulty. On reflection of the vaginal mucous membrane the diseased process was found to extend farther laterally than had been suspected; and this development, hindering the descent of the uterus on traction, rendered the operation anything but an easy matter. Much hemorrhage occurred during enucleation, and clamps and ligatures were used freely. Toward the close of the operation, in removing a matted mass of tissue, the bladder wall was incised, but the incision was immediately sewn up with carbolized silk. The operation altogether lasted two hours.

As concerning the hysterectomy, the patient convalesced fairly well. The clamps were removed on the second and third days, and a small piece of sloughing tissue soon after was discharged. But in about a week the silk suture used in closing the bladder wound came away, and from that time incontinence of urine began to develop, until finally it became complete. A Jacques' winged catheter was constantly kept in the bladder, and this cavity well syringed twice or thrice daily in the hope that the fistulous opening would contract. So soon, however, as the catheter was removed, the urine trickled away per vaginam, and this complication impeded convalescence materially.

She left London and returned to Hastings to still further recuperate, ere any attempt was made to close the fistula, and in the course of a few weeks returned to town for the requisite plastic operation. The whole of the urine was now discharged through the vagina, and the patient's condition was necessarily one of acute discomfort.

In October the operation for closure of the vesico-vaginal fistula was performed. The fistulous opening was irregular and distorted; and the mucosa of the bladder bulged through the aperture; this latter would readily admit the index finger at least. The uterus being absent, it was impossible from the conditions to make the vaginal wall taut, and to further complicate matters the opening into the bladder was in part closely connected with the cicatrix of the previous operation. Segment by segment the fistulous edge was straightened out and pared, and this part of the operation was extraordinarily tedious and difficult. The eversion of the bladder mucosa, the distorted edges, and the attachment of these to adjacent cicatrix, with the impracticability of putting the whole on the stretch, evoked an unusual amount of patience and resource. Finally, sutures of silk-worm gut were passed and tied; the bladder was distended with fluid to test its integrity and the patient put back to bed. A Jacques' winged catheter was

retained for more than a week in the bladder, and the vagina very carefully douched with antiseptic fluid.

On removal of the winged catheter eight or ten days after operation, it was obvious that the vesical leakage had not been arrested; urine still trickled from the vagina, and a fortnight after the first a second attempt was made to firmly close the fistula. This operation was even more difficult than its predecessor, as the sinuous outline, the crumpled and cicatricial edge, and the textural looseness of the surrounding tissue rendered exactitude in apposition of pared edges still less practicable than before. A similar method of operation and a similar after-treatment were adopted, and a second time the result was unsatisfactory.

I now determined to adopt a more radical but less difficult procedure, and close the vagina immediately below the lower limb of the fistula. A segment of the vagina, intervening between the cicatrix of the primary operation and the plane of the lower extremity of the fistula, would thus be made continuous with the bladder, but discontinuous with the vagina. This operation was accordingly performed about three weeks after the second plastic procedure, and the result was from the first satisfactory. Urine ceased to leak after the catheter was withdrawn, the retentive capacity of the bladder was once more established, and the incontinence was now abolished.

Colpocleisis has been the resource of other operators when plastic operations on the fistulous opening itself had proved useless or impracticable. It is a comparatively rare operation, and its development as an effective procedure we owe to Professor Simon of Heidelberg. Vidal de Cassis had previously performed labial occlusion for the same end; but this method has proved far less satisfactory than Simon's procedure, which is now the plan of election when more direct measures are inutile. The small segment of vagina incorporated in the bladder tract appears to cause neither inconvenience nor urinary concretion; and in this

instance, as the uterus had been removed, there were no secretions to intermix with that normal to the bladder. Hegar and Kaltenbach deal fully with this subject, and cite ten cases of Professor Simon's, under observation for from five to ten years, where no contingent difficulties had supervened. Bantock also, as narrated by Doran, has employed this plan in at least one case, and with similar good results.

## INTESTINAL HEMORRHAGE IN INFANTS.

By A. A. LOVETT, M. D.

THIS is a very unusual condition, and the two cases coming so closely together has, as a matter of course, set me investigating. I am unable to determine the cause of the hemorrhage in these cases. So far, I have met no one, on inquiry, who has had similar experiences, and of the various authors at my command, seven in number, Fisher alone refers to it, and he in a most general way. He says hemorrhages may occur in almost any organ of the body, or from almost any outlet of the body, and result disastrously, if excessive. No further reference is made to the subject, except in that he says "syphilis in parents may be the cause," which had no part in either of my cases. Keating is entirely silent upon the subject. In neither of these women is there any history of a hemorrhage diathesis. I regret very much that a *post-mortem* was not held, as some light may have been thrown upon the subject, but I presume I would find nothing but a general capillary hemorrhage of the intestinal mucous membrane. If others have had similar experience, I would like to hear from them.

In February of 1895 I delivered Mrs. C. of a fine, large child weighing about ten pounds, strong and active. Everything was right and promised well. When child was about thirty hours old he vomited blood once or twice. This



was followed in a few hours by bloody stools, which soon amounted to hemorrhages. The stools were frequent and large, and consisted almost entirely of dark, coagulated blood. They continued frequently, until the child expired during the third day. The amount of blood passed seemed incredible for a child of that age. Mrs. C. had given birth to a child prior to this; also has given birth to one since. Both are living and healthy. The last child vomited blood on the second day, but soon recovered.

During April, 1896, I delivered another lady of a large, healthy, finely developed girl baby, weighing 10½ pounds. In a few hours it vomited blood, immediately followed by profuse intestinal hemorrhage, similar to the one above related, and continued bleeding until it died on the third day. This lady had previously had three healthy children, two of whom are living.

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### A PLEA FOR THE SYSTEMATIC EMPLOYMENT OF THE BACTERIOLOGICAL TEST IN DIPHTHERIA, WITH ILLUSTRATIVE CASES.\*

BY J. ROBERSON DAY, M. D.

**T**YPICAL cases of diphtheria are sufficiently characteristic that a mere tyro in the healing art may be expected to arrive at a correct diagnosis. It is the atypical form of disease which calls forth the acumen of the physician, and no problems are of greater import. Upon a correct diagnosis may depend either the spread or the arrest of an epidemic, and in the case of children the multifarious issues involved of interrupted studies, infected healthy homes, constitutions wrecked, or possibly even death left in its train, are consequences sufficiently obvious to afford abundant material for serious reflection.

The difficulties which beset the path are great. The

\* Also published in the London *Homeopathic Review*.

patient may never feel sufficiently ill to require medical advice at all, and all through the infectious stages has been allowed freely to mix with other children. Such cases later on are brought to us with various paralytic sequelæ, causing indistinct speech, regurgitation of fluids through the nose on swallowing, or possibly with a squint. The parents, notwithstanding their proverbially watchful eyes, have completely overlooked the earlier phases of the malady. In such cases the physician must be exonerated from all blame.

In another group of cases we are consulted for some slight throat complaint, so light, indeed, that the visit of the patient is coupled with an apology for troubling us for such a trivial matter. We inspect the throat, and discover nothing very seriously wrong, and prescribe the similimum best suited to the case, and straightway on the next visit the throat is well. In some three or four weeks, however, the glory of such a speedy cure has to be discounted, when the patient returns with the loss of knee jerks and various pareses. Who has not had such an experience? We plead guilty, and can recall a family of three children whose diphtheria was only diagnosed by the post paralytic symptoms, which, in the case of one, proved fatal from cardiac syncope.\*

Yet another group of throat cases calls for treatment where the constitutional symptoms are marked and the local signs are highly suggestive, although equivocal; in this are included acute tonsilitis, follicular tonsilitis, scarlatina, and diphtheria. Scarlatina can be eliminated in twenty-four hours, but to distinguish diphtheria from acute and follicular tonsilitis, the character and distribution of the membrane is what is chiefly relied on, and here it is that the bacteriological examination is of such value. In acute illness early diagnosis is of the utmost importance, and by this means our suspicions can be confirmed much

\* *Vide London Homeopathic Hospital Reports*, vol. ii., 1892, p. 78.

more rapidly than by the slower process of waiting till symptoms more plainly declare themselves.

The notes of the following cases, three being diphtheria, but of totally distinct types of this polymorphous disease, and one of follicular tonsilitis simulating diphtheria, will illustrate the value of this aid to diagnosis.

CASE I.—M. W., aged  $6\frac{1}{2}$ , was perfectly well on Saturday morning, February 8, 1896. At 7 P. M. she complained of sore throat, and the temperature was taken and found to be normal. She passed a very restless night, with frequent empty retching. I saw her on February 9, and found temp.  $104^{\circ}$  F., both tonsils enlarged and covered with patches of exudation, and also some patches on the pharynx. The glands, at the angle of the jaw, were enlarged and tender. There was no rash on the chest. I gave bell. 3 and acon. 3x alternate hours.

February 10. Very delirious last night, but better this morning, and temp.  $102.6^{\circ}$ ; pulse 132. The cervical glands on the left side were much enlarged and tender. The tonsils were swollen and covered with exudation membrane like acute tonsilitis. There was no rash on the body anywhere. She was feeling better and taking nourishment well. At 10 P. M. temp. was  $99.6^{\circ}$ , with delirium at times, and breath fetid. Tonsils covered with a suspiciously diphtheritic membrane; the glands on the left side were very much swollen and tender. Medicine changed to merc. bin. 3x gr. j. om. 2 hrs. To gargle with weak solution of permanganate of potash, and have hot fomentations and the steam kettle.

Diet.—Milk and Vichy water only.

February 11. Passed a restless night, but is brighter and has taken more nourishment, and was less delirious; to-day is quite rational. Throat is now covered with membrane on both tonsils, which meet.

At 1 P. M. I injected 14 c. cm. of anti-toxin serum into the loin, but continued the merc. bin. 3x, and also sprayed the throat with peroxide of hydrogen.

Diet.—In addition to milk and Vichy water, she took Valentine's meat juice 3 j. ter die., and brandy 3 j in 24 hrs., as the pulse was weak and 126. At 8 P. M. the throat was examined and a piece of membrane stripped off (which caused free bleeding) and sent to be examined. There was to-day a thin, offensive discharge from the nose, showing the membrane had extended into the posterior nares.

February 12. Decidedly better this morning; slept at one time 1½ hour—quiet sleep; is brighter and had no delirium last night. The throat was less red, glands less swollen; nose still discharging, but fetor less. 10 c. cm. of the serum was again injected, and merc. bin. 3x continued. At 5.30 P. M. swallows more easily; membrane not extending; urine shows opalescence from albumin on boiling.

February 13. Passed better night; some good sleep; temp. normal. Membrane looks to be detaching itself, and at 6 P. M. was clearing from the throat. Asked for and ate some bread and butter.

February 14. Very much better in the evening; coughed up a large piece of membrane.

February 15. Improvement continues; breathes through the nose. No membrane can be seen in the throat. A rash appeared about the elbows and buttocks just like that she had on December 27 last.

The progress was steady, and on February 19 china 1x 5 drops ter die was substituted for the merc. bin. 3x.

February 24. A slight nasal twang was noticed in her voice; this continued, but never caused regurgitation of fluids through the nose. On March 6 had slight, sudden pallor, and again on March 9, when the knee jerks were found absent.\*

March 10. Heart's beat irregular, and strychn. phosph. ʒiij. ter die was substituted for the china.

\* "The gravest sequels are paralytic conditions."—Sir Dice Duckworth, *British Medical Journal*, p. 834. 1896.

March 16. Eyesight noticed defective, and on March 20 there was marked strabismus from paralysis of right external rectus with diplopia. Shortly after this she left for Exmoor, and on her return the squint had disappeared, but the knee jerks were still absent. This I have before observed is a most persistent symptom.

She is now practically well. I should add that on February 13 the bacteriological report stated the case was one of genuine diphtheria, and the diphtheria bacillus had been isolated.

CASE II.—The second case which I am about to relate was the exact opposite of the preceding, although a case of diphtheria.

L. P., aged  $4\frac{1}{2}$  years, was brought by her mother to my out-patient clinic at the hospital on April 23, 1896. The temperature was  $100.6^{\circ}$  F. and the throat looked *suspicious*, although there was not sufficient membrane for removal, and I had to be satisfied with wiping the pharynx out with a piece of wool, and by this means secured a specimen for examination. It was a noteworthy feature that the throat bled readily, and the wool was covered with blood. The next day, April 24, I received a communication from the Institute of Preventive Medicine saying the pseudo-bacillus diphtheriæ had been isolated—a non-virulent form. The left tonsil had a patch of membrane on it to-day, there was a nasal discharge, and the lymphatic glands in the neck, axillæ, and groins were enlarged. The urine contained no albumin. Merc. bin. 3x was given.

On the 25th the throat was clear of membrane and the nasal discharge was much less.

May 7. Knee jerks tested and found to be present; no signs of paralysis.

On May 15 kali mur. 3d was substituted for merc. bin. 3x, and convalescence was uninterrupted.\*

\* For the notes of this case I am indebted to Dr. Munster, Resident Medical Officer.

CASE III.—On May 1 I saw W. P., aged ten, and learned that five days ago she first complained of her throat, and was feverish and had a headache, but she got better on the third day and went to school again. Yesterday, however, she came over hot and cold, and her throat was again sore, and she was constantly wanting to drink. I found the pulse 146, and temperature 104.4°. Both tonsils were covered with patches of membrane, a portion of which I removed for examination, which caused bleeding. There was a furred tongue, sordes on lips, mouth breathing, glands at the angle of the jaw slightly enlarged and tender. I gave acon. 3x and bell. 3d alt. 2 hrs., and ordered a gargle of hot weak permanganate of potash and hot fomentations to the throat externally.

Diet.—Milk and soda or barley water.

May 3. Was much better, and had slept from eleven till four. P. 112. T. 100.2°. There was a large piece of membrane on the right tonsil and a smaller piece on the left. Merc. bin. 3x gr. j every two hours, was given instead of the acon. and bell., and bread and milk and egg flip added to the diet.

On May 4 I received the result of the bacteriological examination, stating the *B. diphtheriæ* had been isolated. The improvement was steady and continued. The temperature gradually fell to normal on May 9, when all the membrane had disappeared.

CASE IV.—J. W., aged seventeen, sister to M. W. (Case I.) on May 18, 1896, had a patch of membrane the size of a split pea on the right tonsil, which was enlarged, and the lymphatic glands at the angle of the jaw on the same side were swollen and tender. The mother was naturally very anxious from her recent experiences with M. W. The temperature in the morning was 100° F. but at noon when I saw her 98.8° F. The trouble began the previous day with a feeling of sore throat and pain on swallowing. This continued, and I ordered merc. bin. 3x gr. j, every two

hours; hot fomentations to the throat externally and a gargle of hot water colored pink with permanganate of potash. I saw her again in the afternoon and removed a portion of the membrane for examination, but the surface from which it was removed did not bleed, and since the morning the left tonsil had enlarged and presented the well-marked appearances of follicular tonsilitis, the mouths of the follicles being covered with numerous small islets of secretion. However, although the diagnosis was now almost certain, I sent the membrane for examination, and in due course learned that the *B. diphtheria* was not found, thus confirming the diagnosis. She rapidly recovered and left for the country.

*Remarks.*—The above cases will illustrate the value of the bacteriological test, and it may be most certainly relied on to confirm the diagnosis.

Case I. is a type of the most virulent form of diphtheria; its sudden onset and high fever and vomiting made one at first suspect scarlatina, but the appearance of the membrane soon placed its true nature beyond a doubt. This case is further of interest as being treated with the anti-toxin serum, and the result was so successful that one is encouraged to adopt the serum treatment in combination with the use of homeopathic remedies in similar virulent cases.

Case II. is of exceptional interest, for the naked eye appearances were not at all characteristic. In this case, the *pseudo-bacillus diphtheriæ* was found—a variety of the true *B. diphtheriæ*, and one which under favorable circumstances would develop into it, and thereby cause a severe type of the disease.

This is light thrown on the path of medicine by the bacteriologist; it explains how an ordinary, vaguely described "sore-throat" (with pseudo-B. D.), will cause in another patient a severe form of diphtheria. We can see also why it is so difficult to trace the source of infection in diphtheria from this cause.

Case III. is an average mild case of diphtheria. No doubt the patient had been attending school with the infectious throat before her condition was regarded as serious enough for medical advice. The bacteriological test here was of decided value, confirming a diagnosis which was by no means evident.

In Case IV. the diagnosis was pretty clear on the second visit, when the follicular character of the inflammation was well marked; still partly to check the work of the bacteriologists a specimen was sent and a negative result followed. This is a sufficient reply to those who say the *B. diphtheriæ* can be found in any throat even in health, and in all these cases it shows how very trustworthy is the laboratory work, for no information was ever forwarded with the specimens beyond stating the source of the membrane, and a request to examine it for diphtheria.

Finally, I would strongly urge all who are systematically working at the diagnosis and treatment of diphtheria to adopt this simple confirmatory test.

In the schedules for the collective investigation of disease—now very shortly to be issued—this test is also very justly emphasized.

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## APPLICATION OF THE FORCEPS. \*

TRANSLATION BY B. F. UNDERWOOD, M. D.

(Continued from p. 173, March, 1897.)

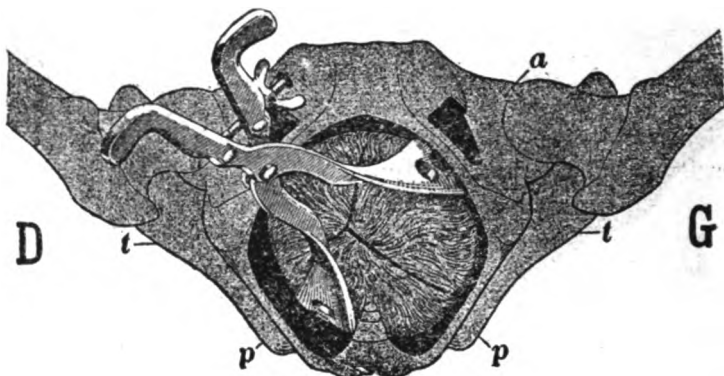
*Movement of Major Rotation Interrupted by a Change of Taking.*—Finally, if extraction with the forceps in a reversed position is dreaded.

Rotation is commenced in the same manner as in the preceding case, and carried as far as the first stage, until the forehead and the forceps are in frontal right, or occipital left transverse position. Fig. 56.

\*From the French of Professor Farabeuf and Dr. Varnier.

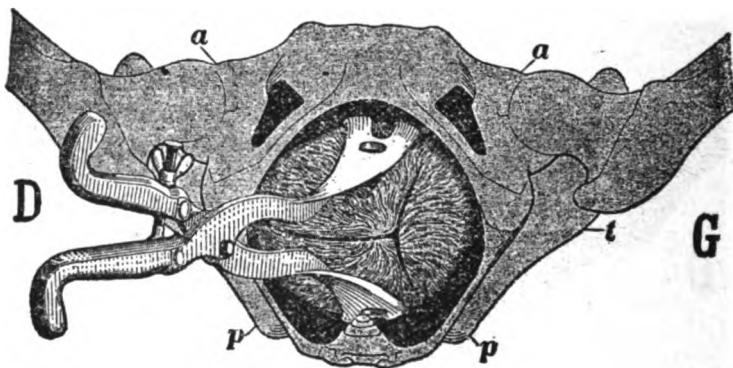


**Figure 55.** Vertex at the inferior strait, in occipital left posterior position. Starting point of the movement of major rotation.



**FIG. 55.**

**Figure 56.** Vertex at the inferior strait in occipital left, transverse position, the result of the first step of rotation



**FIG. 56.**

of 45°, bringing the head from the original position, occipital left posterior.

This position having been obtained a regular reapplica-

tion of the forceps with the pelvic concavity turned the same way as the occiput becomes justifiable.

Raise the forceps and make the application as shown in

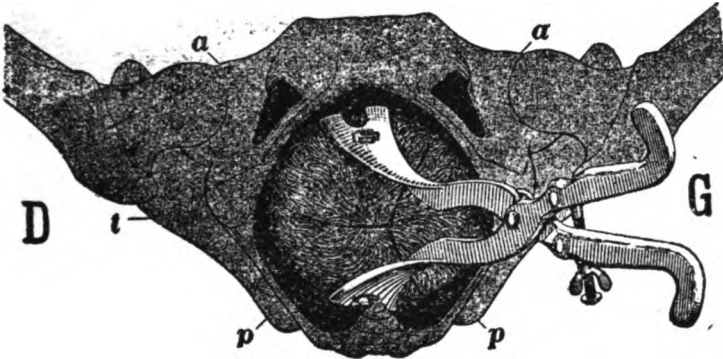


FIG. 57.

Fig. 57. The directions for this will be found on page 269, in the issue of May, 1896.

Figure 57. Vertex at the inferior strait in occipital left

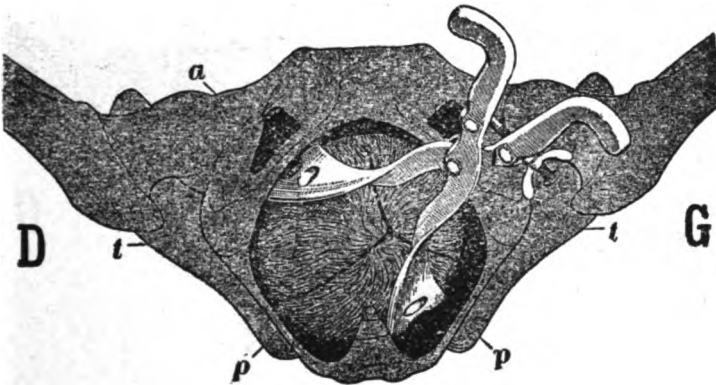


FIG. 58.

transverse position, as in Figure 56; but having the forceps removed and reapplied with the concavity turned toward the left, the same as the occiput.

**Figure 58.** Vertex at the inferior strait in occipital left anterior position, the result of the successive transformation from the initial position, occipital left posterior to occipital left transverse without change of forceps, and from the latter to occipital left anterior after the reapplication of the forceps.

The natural result of reapplying the forceps is that rotation of twice  $45^\circ$  is accomplished, Figures 58 and 59, which rotation, carrying the forehead before the coccyx, brings the occiput under the symphysis pubes, with forceps properly placed to complete the extraction of the head.

**Figure 59.** Vertex at the inferior strait in position of disengagement, occipital direct anterior, the forceps having the concavity turned forward in the same direction as the occiput; the third and last step of major rotation imposed

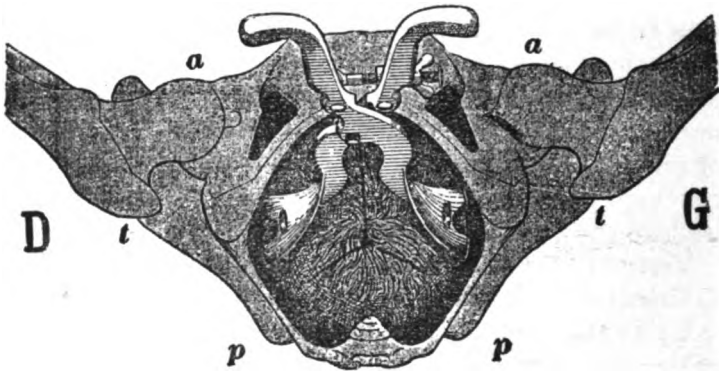


FIG. 59.

by the primitive position, occipital left posterior, *c* and *d*. Engagement of the head in the soft pelvis and extraction through the vulva. After the minor rotation which brings the forehead in front, the forceps being properly placed, the extraction is continued as described on page 529, issue of November, 1895.

After the major rotation, interrupted by the removal and

reapplication of the forceps, the extraction is completed as described on page 273, May, 1895.

It is only after the major rotation, without the removal and reapplication of the forceps, that having brought the occiput in front and reversed the forceps, the conditions are favorable for the termination of the accouchement. The forceps are therefore reversed, the concavity, like the forehead, turned toward the sacrum; the handles are not nearly horizontal, but are turned downward, Figure 54, page 173, March, 1897.

To engage the head in the soft pelvis with the forceps so placed, it is necessary to first exert traction in a downward direction to cause the complete engagement of the occiput, as far as the neck, under the symphyses pubes.

During the horizontal traction necessary to cause the passage of the head through the inferior strait, the handles should remain inclined at an angle, downward. It is necessary to be very careful when making traction to avoid raising the handles too high; nevertheless, it is necessary to follow the progressive deflexion of the head in its course over the soft pelvis and through the vulva. The raising of the handles too high is to be especially avoided, on account of the danger of wounding the posterior inferior walls of the pelvis with the beaks of the forceps.

Vertex in the same position, occipital left posterior, insufficient or no flexion.

Up to this point we have supposed the head flexed, and consequently easily seized at the first attempt, by the parietal eminences and the cheeks. But if, as sometimes happens, the application of the forceps upon the head, immovably fixed in the oblique posterior position, becomes necessary, the application should not be attempted until it is found that the head is incompletely or not at all flexed; then, by the touch, the grand fontanella, the bregma, which, when the head is well flexed is not accessible to the finger, being behind the descendant branch of the pubes, may be easily felt.

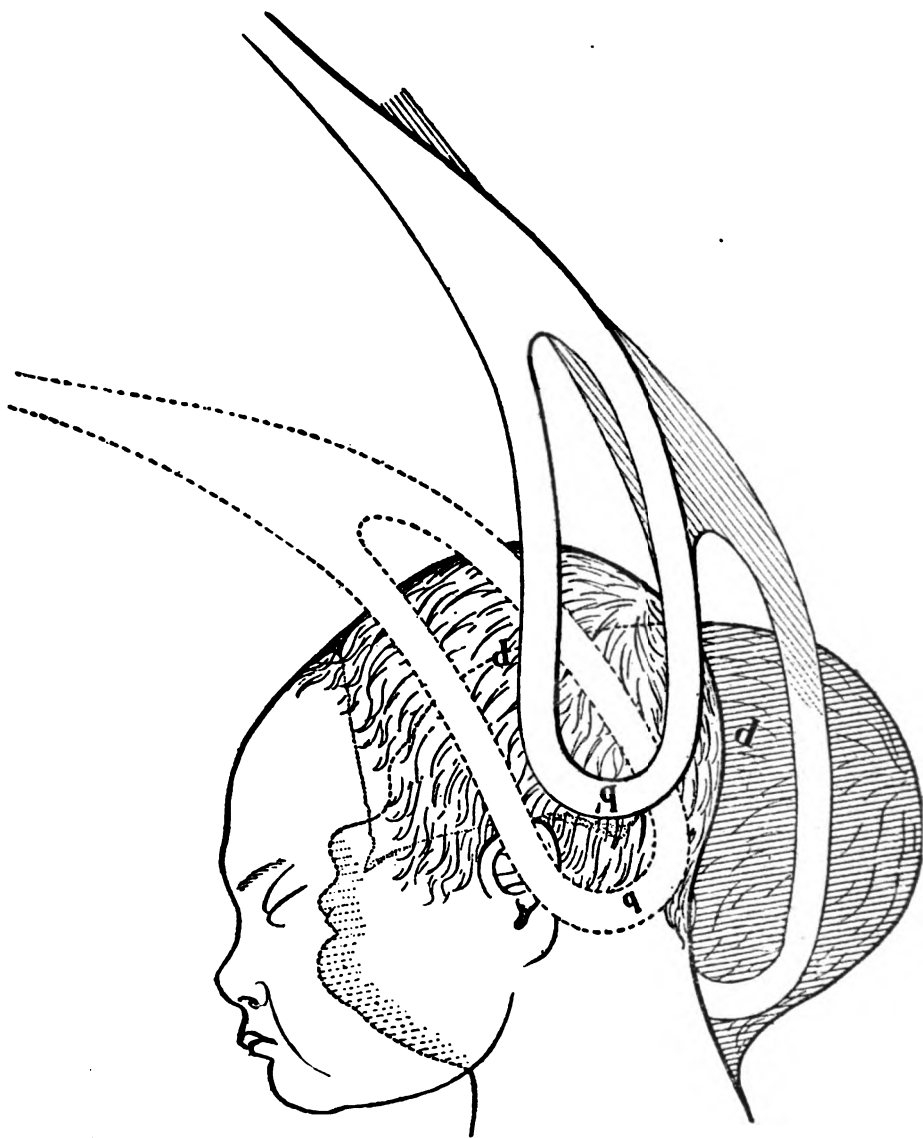


FIG. 60.

When this condition is presented it is necessary to first complete flexion by an application of the forceps for this purpose alone. Figure 60 shows how to succeed in seizing the head by the bimastoidean diameter.

This application is made by introducing the guiding hands and the blades in the order and manner indicated. The ears, particularly the posterior one, still remains the mark of certainty. The blade is applied posteriorly, encircling the mastoid apophyses, fitting closely the posterior border of the ear and not raised higher than the lobule. Traction upon the forceps produces first flexion and then the loosening of the instrument, which it is necessary to raise carefully, so that it does not slip as soon as flexion is made. When the head is flexed the forceps are to be removed and reapplied in the manner described.

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## THE ACCOUCHEUR'S RESPONSIBILITY.

BY E. T. A. DRAKE, M. D.

**T**O my mind the study and practice of obstetrics is invested with graver responsibility, and about it are grouped more questions of public and private import than obtain in any other branch of medical science.

The surgeon has to do with the life or death of the individual, the obstetrician with generations yet unborn.

The chemist, the pathologist, the sanitarian the physical culturist and the hygienist are but adjuncts after all to the accoucheur, who but aid and give strength to the great work which he is set to accomplish.

The obstetrician stands at the very gateway of life to insure a safe entry into its portals, to the little beings whose after destiny will make or mar the community in which they move.

He can do little with the generations behind save to note the rocks over which they stumbled that he may

better direct the generations which he guides. In the *present* lies his *great* work, its *success* will be chronicled in the *future*. The *past* is but a guide board.

Do not understand me as underrating the necessity for skill in the obstetrician ; and all the careful and painstaking preparation, not only for the ordinary cases, but as well for the emergencies of practice. "These ought ye to have done and not to have left the other undone." His work begins but does not end here.

He needs, aside from his skillful preparation, to see his opportunity in the education of the fathers and mothers, in the attempt at least to make each succeeding generation a little better and stronger than the one which preceded it.

He should be at heart a philanthropist in the broadest sense, with his face set like a flint against the beguiling evils that appeal to his pocket-book through the sacrifice of principle.

Who better than the warden that stands guard at the gateway of life, and watches with painful interest through the throes and pangs of motherhood the ushering in of the many deformed, not physically perhaps, but what is more sad, mentally and morally deformed ; the nervous wrecks, setting up in the business of life bankrupt, and burdened with debts which they perforce *must* pay—who better than the "watchmen upon the walls" can send out the *warning* cry, and demand the attention of the philanthropist, who has more time to push the work along the lines which he, the physician, marks out. Who better than he, can by word of wisdom and counsel, point out the possibilities within the reach of *all* parents, of endowing their children richly or of robbing them of their birthright, the right to be well born ?

Who better than he can repeat the fearful text, "the sins of the fathers shall be visited upon the children unto the third and fourth generation," and emphasize it with repeated object lessons of specifically diseased children,

who have gotten from their parents a heritage of woe, which they in turn transmit to generations to come?

Who can teach these lessons of heredity with such a fullness of meaning, as the physician who, learning the history of his patients, can say, "You inherited this or that unmistakably, take care and you need not transmit to your children as dire evils; they have enough from the generations behind."

It has been said would you reform a man begin with his grandfather. Here the physician has a wider opportunity than any other. Sow the right seed in the present generation and you may be sure that a part at least will bear fruit in the grand-children of your patients.

We need to study this great truth of transmission of moral and physical taint, until the lessons are burned so deeply into our own hearts, that we must of necessity speak out and compel a hearing.

Visit our almshouses and reformatories, our orphanages, our idiot asylums, and get a few of the histories of the little inmates; trace them back, if possible, for three, four, or five generations, and see how unmistakably woe has generated woe, crime begotten crime, and disease brought forth disease.

Let us study the dark side of the picture of heredity, and seriously ask ourselves if it isn't time a new reform were instituted and the heart of philanthropy set to beating in sympathy, not only with this great army of robbed, disinherited children, but as well with the yet unborn generations. The great work done for them must be done *now*, not after they are ushered into a depraved, diseased existence.

A splendid operation was performed a few days since by the surgeons in our hospital, with the *possible* hope of bettering the fortune of a poor little idiot ten years old who could neither walk, talk, nor feed himself. This fine piece of surgery, with all the skill and delicacy enviring



it, can be more than matched by a finer work chronicled in the heart of every true physician, who by word of his has startled the expectant fathers and mothers into a preparation for parentage that shall give to the world not an idiot, but a healthy child fully endowed, that shall prove a blessing to his kind.

The surgeon, delicate and skillful as he may be, is but doctoring away at the ugly excrescence, while the seat of the disease lies far behind the surgical history.

Again, the physician should be the teacher of the parents who in turn become teachers of their children, in response to the numberless questions which inquisitive childhood puts, and to which it demands an answer.

The questions relating to their being and to the mystery of procreation are legitimate ones and demand a patient hearing. They should be met with such pure candor that they shall never in the minds of innocent childhood be clothed in a mystery which is too often interpreted as sin.

Parents are awaking to the knowledge that the child is not too young to properly understand these great life truths, when he begins to question about them ; and many parents have learned to their sorrow that they have delayed this answer too long, when they find their children, grown impatient at the delay, have gone to other and often impure sources for their information.

To these thousands of parents who are not aware of their responsibility, how many a lesson might the conscientious physician teach by virtue of his office as confidential adviser and wise friend. I have read somewhere of a great physician who gave finely illustrated lectures to women upon the subjects relating to maternity.

One wise mother who had listened with rapt interest to his great talks, called at his office one day with her twin boys, seven years old.

"Doctor," she said, "I would like you to show my boys the beautiful anatomical plates that you use in your lectures, and tell them about some of them."

"Certainly, madam," he replied, "I will gladly do so.

He turned them over one by one, answering an eager question here and there put by the bright boys, until he came to the one illustrating twin pregnancy, which he hastily put aside, without giving an opportunity for sight or question.

"Stop, doctor!" said the mother, "that's the very one I want my boys to see. I have promised them that as soon as they were old enough I would tell them all about the little room in mamma's body, where they grew for nine months before they came into her arms."

The doctor was struck with confusion and could not utter a word. He who had stood before great audiences of adults and taught them unblushingly the secrets of being was silent before innocent childhood.

The mother was herself forced to be the teacher when she had looked to one wiser to enforce the lesson.

Standing in the presence of the great doctor she told them in pure sweet words the story of their prenatal life, and of her motherhood, not forgetting to tell of the great pain which was all forgotten so soon in the gladness that her baby boys were born to her.

She finished, and there were tears upon the faces of all her listeners. "Oh! mamma! how good boys ought to be to their mothers," said one of the twins; while the doctor exclaimed, "Madam, that was the finest lecture upon the subject to which I ever listened. Go on teaching your boys, and they will become men the world will be proud of and greatly needs."

This is the kind of seed-sowing which not only bears a rich harvest of purity and innocent knowledge, but as well keeps out the weeds of sin and impurity which curiosity gratified by secret whisperings always sows.

Who better than the obstetrician, called to minister at the bedside of the suffering mothers, can institute the beginning of such teaching. *One mother so taught means*

*more for humanity than scores of brilliant surgical achievements.*

And what can I say of the monstrous evil which has grown to larger proportions in this land than in all other nations put together—the sin of ante-natal infanticide.

Such a subject brought before a company of reputable physicians, should come with an apology, were it not that so many of *this* class even, say practically, "If I am not a party to this sin, I stand clear, my duty is done."

No! your duty is not done. You stand or *should* stand as guardsmen of the unborn generations; as educators of public opinion along these lines, and your pen, your voice, and your practice should form a trinity of power against the advance of this alarmingly threatening evil. Threatening to the best instincts of the moral nature of our time. Threatening to the future of our land when we consider the very few children born into our better homes; while in the byways among the lower classes the little ones swarm in hotbeds of sin.

Into every physician's office there come mothers with pitiable appeals; and with reasons that seem almost tenable were it not for the great moral question of life and death which lies behind.

To such we can offer little but commiseration; and here we have need to exercise great care lest such examples, which are legion, tempt us into a false reasoning, which makes us party directly or indirectly to the sin.

No thwarting of nature has any ground for excuse; and the so-called physician who peddles any theory or device for so doing, has no right to the name, or to recognition among the ranks of the reputable of our honored profession.

We hear all over our land of mother's meetings, and they mark an era in the work of woman which is bound to tell upon the future; but what of the father's meetings which ought to be instituted?

They, the fathers, after all, are too often enthroned in

the strong citadel of selfishness against which our guns should be directed. They after all are the arbiters of the destiny of the coming generations.

Dr. Holbrook, in an article on sanitary parentage, says : "That which polite language veils under the designation, social evil, and which desolates so many happy homes, and brings its quick black harvest of misery, remorse, disease, and death, chiefly lives because man does not know aright, does not truly reverence and honor woman, and keep in subjection that which may become one of the monster passions in his heart, and is thus continued from generation to generation."

"You cannot lay one wrongful touch upon motherhood, but you mar a coming generation," says another. "Bind the mother with chains and you beget a race of slavish creatures."

"Each evil pointed out, each wrong discerned, helps the progress to that day when a higher, nobler generation will possess the earth."

A great part of the work to this issue belongs to physicians.

"Do thy work nobly and against all odds," should be the watchword to the onward march; and a good motto for the office the following:

"You don't seem to boast about your ancestors?"  
"No, I'm too busy fixing things so that my posterity and the posterity of my patients can brag of me."



## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

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**THE DISEASES OF INFANCY AND CHILDHOOD ; FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE.** By L. EMMETT HOLT, A. M., M. D., Professor of Diseases of Children in the New York Polyclinic, etc. With 204 illustrations, including seven colored plates. New York : D. Appleton & Co., 1897. Pp. 1117.

This is eminently a practical work upon the diseases of infancy, in which the author treats the subject from the fullness of his own experience, giving, as is not always the case in these days when bacteriology seems to be the sum and substance of many books upon diseases, exceptional attention to the description of the different diseases and their diagnosis ; the pathological description is also very full and clear. It is more particularly a work upon the diseases of early childhood, for in the words of the author : "The pathology and symptomology of disease in children who have passed their seventh or eighth year really differ very little from those of adolescents and young adults. It is in infancy and early childhood only that the peculiar conditions exist which separates pediatrics from general medicine, and entitles it to be ranked as a special department"; and in his treatment of the subject Professor Holt has kept this fact in mind, so that omitting much that was irrelevant he has been able to give in the compass of a single volume a complete treatise upon pediatrics. Infant feeding and infant hygiene the author regards as the most important departments of pediatrics, the well being of the child, and even of the adult, depending largely upon the management of the infant during its first year.

The first part of the book is devoted to the Hygiene and General Care of Infants and Young Children, discussing bathing, clothing, feeding, vaccinating, etc., and then passes on to the Growth and Development of the Body and Peculiarities of Diseases in Children. In Part II. Diseases of the Newly-born are

taken up ; also, under Nutrition, the infant's dietary, the derangements and diseases due to faulty nutrition. Part III. discusses the acute diseases of the Lungs and the Intestinal Tract, and in Part IV. the Specific Infectious Diseases, some two hundred pages being devoted to this purpose, diphtheria receiving very careful attention, the entire work representing the present state of medical science in its relation to the diseases of infancy. The illustrations are mostly from drawings and photographs of the author's own cases. The colored plates and charts deserve especial mention.

**HEART REPERTORY.** By JOHN H. CLARKE, M. D., Consulting Physician to the London Homeopathic Hospital. London: E. Gould & Son, 1897.

This little work is an appendix to the author's work upon Diseases of the Heart and Arteries, and has been compiled from that work. In the arrangement of the repertory the schema form has been taken for the basis, and the symptoms arranged in alphabetical order under each section, so that any desired symptom can be easily found. In connection with the other book, it will prove useful in aiding in finding the remedy in these affections.

**ORGAN DISEASES OF WOMEN, NOTABLY ENLARGEMENTS AND DISPLACEMENTS OF THE UTERUS AND STERILITY, CONSIDERED AS CURABLE BY MEDICINES.** By J. COMPTON BURNETT, M. D. Philadelphia: Boerike & Tafel, 1897. Cloth, \$1.00.

Under this somewhat peculiar title, which might be paraphrased into diseases of the peculiar organs of women, Dr. Compton Burnett has given us one of his interesting and instructive books. He writes always so clearly and so interestingly that if what he has to say were much less worth the saying than what it is we should still read it with pleasure. The keynote of the present work is the amenability of the commoner diseases of women to successful treatment by medicines administered in the ordinary way by the mouth.

Dr. Burnett has been somewhat severely criticised on account of his falling away from homeopathy toward organopathy (the treatment of organ disease by remedies having specific action upon such organs), which he claims to be a crude kind of home-

opathy, and vigorously defends himself in his own inimitable style. We do not intend to try to paint the lily by commending this book, for it requires no commendation. The practitioner who cannot gain something of value from it has no need of books.

TRANSACTIONS OF THE HOMEOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK, for the year 1896. Vol. xxxi.

Our thanks are due the able secretary of Homeopathic State Society for a copy of the transactions of the 45th annual meeting, containing a number of interesting and valuable papers.

## Materia Medica.

***Caulophyllum in Post-partum Hemorrhage.***—Hemorrhage from relaxed condition ; following too quick labor ; profuse flow ; want of tone ; uterus relaxed.

***Ustilago in Metrorrhagia.***—Dr. Dewey, Med. Cent.—Bright, partly clotted hemorrhages from passive congestion of the uterus ; brought on by so slight a cause as a digital examination.

***Aletris far. in Abortion.***—Dr. Danforth.—Habitual tendency to abortion ; sensation of weight in the uterine region, and tendency to prolapsus ; myalgic pains, simulating " false pains " during pregnancy.

***Natrum Muriaticum in Infantile Constipation.***—Is often of great service where the stool is so large as to cause fissures, and these fissures are so sensitive that the child holds back the contents of the rectum.

***Echinacea Angustifolia in Diphtheria.***—Dr. Swarmstedt.—S. J. of Hom.—Profound depression ; chilliness and aching all over ; tonsils congested and swollen ; tonsils and pharynx covered with leathery looking membrane.

***Phosphorus in Mammary Abscess.***—Dr. Richardson.—Phlegmonous inflammation ; breast swollen ; red in spots or streaks ; hard knots in different places, with fistulous openings, with burning, stinging and watery, offensive discharge.

***Glonoïn in Albuminuria of Pregnancy.***—Dr. Christine.—Congestive conditions where there is an increased flow of urine,

albumin (due to hypæremia of the kidney); heart and head symptoms of pulsation and quick throbbing; frequent desire to urinate at night; rush of blood to the head.

***Causticum in Enuresis.***—Under causticum we have an excitable condition, some of the same hyperæsthetic condition which we find under pulsatilla, with this difference: under pulsatilla the hyperæsthesia is general, and affects the whole organism similarly, while causticum is prone to select single nerves or special centers.

***Carbo. an. in Leucorrhœa.***—Dr. McElwee.—The leucorrhœa is not so yellow when voided, but stains the linen yellow after exposure to the air or after getting dry. The discharge is thin or watery, offensive and very acrid, biting, burning; in scrofulous subjects who are prone to homesickness, if abroad, or excessive merriment, in paroxysms.

***Senecio Aurens in Gynecology.***—This remedy is useful in amenorrhœa and dysmenorrhœa, accompanied by nervousness, hysteria, and insomnia; the indications for its employment are mostly clinical. In uterine irritation from displacement, flexion or prolapsus, spamenorrhœa, pain in the neck of the bladder which is relieved as the flow becomes more profuse, it is an effective remedy.

***Esculus Hip. in Ovarian Disease.***—Dr. McMichael.—Pain starts in right ovary, and runs through the hip to back, with throbbing behind symphysis pubis.

Concomitants: Leucorrhœa, dark yellow, thick, sticky, acrid, and worse after menstruation. Constant backache; dry, uncomfortable feeling in rectum, as if filled with small sticks. Ulceration of cervix, accompanied by hemorrhoids.

***Rhus Tox. in Measles.***—Dr. McElwee.—St. Louis J. of Hom.—The peculiar restlessness of this remedy would lead one to suspect its need, but the symptoms that have led to my use of it have been the peculiar color of the rash, it being of a tawny, dusky, or mahogany color, accompanied by the peculiar dry, red, cracked tongue, and the itching. Some of these cases have been accompanied with rheumatic pains which were always worse at night, and ameliorated by motion and heat.

***Coccus Cacti in Pertussis.***—Dr. Conzelman.—Whooping cough accompanied by excessive secretion of mucus; ropy,



tenacious, and difficult to expectorate, causing the child to strangle. Paroxysms of cough as soon as the child awakens in morning; ends in vomiting of clear, ropy mucus, hanging in long strings from the mouth; it racks the whole system, head pains as if it would split, face purple; in second stage, suffocating cough with expectoration of much tough, ropy, white mucus—which accumulates in chest and throat, difficult to raise, causing strangulation and vomit of food; bronchial catarrh remains after protracted spell of whooping cough; irregular urinary secretions, hematuria, excessive deposit of urates and uric acid.

***Sabina in Uterine Disease.***—Dr. Cowperthwaite.—Sabina gives rise to congestion and inflammation, and this results in the characteristic uterine hemorrhage in which its curative virtues have been so repeatedly and unquestionably displayed. In hemorrhage after abortion or confinement the blood is dark and clotted, but in menorrhage it is red and profuse. The os is wide open, and a condition of atony present. An important characteristic is a pain extending from the back through to the genitals and sometimes down the thighs. It is said to be especially useful in gouty subjects. It has been successfully used in dysmenorrhea, leucorrhœa, and threatened miscarriage, with the characteristic pain from the back to the pubes.

***Lead Poisoning and Habitual Abortion.***—Dr. Daniel (Journ. d'Accouch.) publishes an account of a woman, now aged thirty-seven, who has been eighteen times pregnant, and has aborted at between the fourth and seventh months of the last sixteen pregnancies. The first child was born in 1880, the second in April, 1882; they have grown up healthy. In 1882 the husband became a house painter. Lead colic occurred soon after, followed by paralytic symptoms. He has had to give up his work for months, but has always been obliged to resume it in order to earn his bread. In 1884 the wife aborted, and fifteen abortions followed. Her health seemed to improve during the first month or two of pregnancy. Suddenly a kind of nervous attack would occur at night, a rigor with a sensation of fear. By the morning the breasts were found flaccid; within a week the dead fetus was expelled. Within a few days the patient felt well again. She seemed free from any of the symptoms which afflicted her hus-

band, and neither had been subject to tubercule, syphilis, or alcoholism.

***Calcareo Iod. in Rachitis.***—Dr. W. T. Ord.—The child, aged three years, had never attempted to walk, was unable to stand or even raise himself up. A well marked case of rickets, all the usual symptoms present. Was lively and cheerful and had a good appetite. Bowels confined. Ordered calc. iod. 3x, gr. iii t. d. s. In a fortnight there was decided improvement, the child making attempts to get up. One month from commencing calc. iod. a tooth was cut. A fortnight later voluntary attempts to stand and walk were made. Silica was now tried for a fortnight, but though progress was continued, calc. iod. seemed to suit best and was returned to. Four months after commencing medicine the fontanels were closed, and the child could stand. In another month he walked well, the symptoms were all greatly diminished, the child vigorous and strong. Treatment was somewhat hampered by ascarides, which were disposed of by teucrium. Convulsions were caused by them once, but yielded to belladonna. Altogether calc. iod. was given for five months.

***Nux Moschata in Prolapsus Uteri.***—Dr. Andrew M. Neatby.—Hom. Review.—Mrs. G., aged thirty, June 18, 1896. Has suffered for many years "from prolapsus uteri." The trouble is constantly brought on by exertion even of trifling character. A comparatively short walk is enough to cause a "descent of the womb." (I made no examination. Prolapsus uteri was the diagnosis given by the patient's former adviser. Her own account of what occurred was that a tumor like an orange appeared externally, and that a discharge issued from it.) She had worn two ring pessaries, but had discontinued their use as she was unable to retain them. They came out with every motion. She suffers from constant pain in the back below the waist, and from a dragging pain from the shoulders downward. The pain is worse just before each period, but there is no pain during the period. She has no bearing down sensation. The period is sometimes seven days too soon, and sometimes fourteen days too late, and is occasionally profuse. She frequently has a troublesome leucorrhœa for a week before the period. There is an occasional headache right through the

temples just anterior to the ears. She complains also of pain at the back of the neck. She sleeps well, but gets drowsy by about 9 P. M. She has long suffered from palpitation, which is worse on exertion or on going to bed. There are no dyspeptic symptoms; no "globus" or faintness; but sometimes numbness of fingers. *Nux moschata* 4x, *m* iii. ter.

June 25. Says she is not nearly so languid, and is in better spirits. Her sleep refreshes her better, and she suffers less from palpitation. The dragging pain from the shoulders is less. Continue.

June 29. Feels more equal to exertion. "Things are not such a trouble." Continue.

July 13. Has been free from the prolapse since beginning the medicine. Yesterday had some trouble with the pain in the upper part of the back. The pain over the sacral region is better. *Nux moschata* 30, pil. iii. ter.

July 20. Altogether much better. Feels very little of the pains in the back, and nothing of the pain in the neck. Has entirely lost the nervous restless feeling she had. Has much less palpitation but still some headache. The leucorrhœa has disappeared. There has been no return of the prolapse, though the patient has frequently made such exertion as always formerly sufficed to bring it on. The last period came on prematurely. *Nux moschata* 30, p. iii. n. and m.

July 27. Feels better in every way. Is in better spirits and not so easily tired. No pain in the back. Headache much better. There has been no return of the prolapse, but has had a very slight, irritating leucorrhœa. Continued.

August 4. Describes herself as better than she has been for a great many years. The leucorrhœa is better. She is free from the pain in the back and continues entirely free from the prolapse, though working harder than when she was constantly suffering from it.

No local treatment has been adopted in this case. There has been no change of air or rest of any kind. During the treatment the patient's circumstances have been getting more and more trying.

I directed her to take the same medicine once a day and discontinued my attendance.

Remarks.—One leading indication for *nux moschata* was the variableness which characterized the menstruation. Farrington (Clin. Mat. Med., p. 111) has noted the changeable character of the nervous symptoms of this drug. A variable humor is also recorded under *nux m.* in the Cyclopedia (iii. 417, 423). It is further observable in the Cyclopedia poisonings, that in many of the cases recorded the drug was taken under the impression that it was valuable in the treatment of various uterine troubles, such as delayed, arrested, or profuse menstruation, and leucorrhœa. Case 13, on p. 425, seems to show a marked action on the uterus and ovaries. A similar action is observable in Case 14, though there it is less striking.

On p. 416 of the Cyclopedia (vol. 3) there are two provings, in one of which menstruation was premature, while in the other it was delayed. In the latter, when menstruation was due there was only a slimy discharge. It will be observed that in my case the period was preceded by leucorrhœa.

Drowsiness, lassitude, and palpitation occur repeatedly in the Cyclopedia under *nux moschata*.

Irregularity as to time and quantity is noted by Lilienthal (Hom. Therap., p. 733) as being characteristic of *nux moschata*. The same author refers (p. 673) to this remedy under leucorrhœa in connection with prolapsus and palpitation.

The remaining symptoms will be found substantially in Jahr.

The patient was seen again on the 17th of September. She continues free from the prolapse, and says she has enjoyed better health the last two months than she had known for eight years previously. She has just overtaxed her strength very imprudently, but has done so with impunity except for natural fatigue and a return of the pain so slight as not to be compared with what she formerly suffered. Menstruation is now regular.

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## Obstetrics.

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**Multiple Pregnancies.**—Dr. M. E. Douglass records 462 cases of labor, 4 cases of twins. Dr. W. A. Hasler, 2587 cases and 14 cases of twins.

***Dystocia Due to Retention of Urine by the Fetus.***—Dr. Saintu (Jour. de Med. de Paris) reports the case of a woman upon whom it was decided to induce labor at about the eighth month on account of a contracted pelvis. Saintu delivered the head, shoulders and thorax with ease, but the rest of the labor was conducted with great difficulty on account of immense distention of the fetal abdomen. The child did not urinate until the next night, when it passed a large quantity of urine, and catheterization removed more. The child died the next evening. At the autopsy the bladder was found to extend to the ensiform cartilage above, and laterally to the sides of the abdomen. The urethra was perfectly patent.

***The Course of Pregnancy and Birth in Uteri with Vaginal Fixation.***—Dr. Werthein (Centralblatt für Gynäkologie). After briefly describing the ordinary shape assumed by the rising uterus, its intensely thin posterior wall and fixed thickened anterior wall, so that the os becomes almost impossible of access, he proceeds to the matter of treatment. Version seems to be the only method advised, unless Cæsarean section be resorted to. Its practice is attended with great difficulty. In the cases cited by the author the fetus seemed always to have been in the transverse position. In such cases of uteri with vaginal fixation there would seem to have been but one outcome of the labor, namely, rupture of the posterior wall. So far as the patient's future is concerned there seems little gained by abdominal fixation beyond that derived from vaginal attachment. In any case it makes a pregnancy in a uterus attached by its anterior wall a matter of great danger, and such operations, except where pregnancy is not a probability, is of doubtful advisability.

***Management of Labor in Posterior Positions of the Vertex.***—There are not a few cases of labor in which the occiput presents posteriorly where the physician can save himself much time and anxiety by acquainting himself with the position of the child before labor and advising appropriate treatment. The fact that the anterior position is the normal one should lead the physician to have the fetus assume this position before labor begins. This can usually be accomplished by postural treatment of the mother. She should be directed to assume the knee-chest or the

knee-elbow posture several times daily, and to remain in this position as long as possible without fatigue, and upon resuming the reclining posture she should lie on that side toward which the fetal back is looking. In the event of not securing anterior position of the child, the most important thing is to secure complete flexion of the head and maintain it throughout the progress of the labor. This implies a frequent examination, both before and after rupture of the membranes, and is, therefore, an exception to the plan of modern aseptic management, which discourages repeated examinations. The occiput of a well-flexed head will almost certainly become anterior when it reaches the perineum. If, for any reason, this mechanism does not occur, what measures shall be adopted to effect delivery?

These naturally vary with the high or low position of the head. If the head becomes arrested at the brim, one or another of three plans of treatment may be resorted to: 1. Efforts may be made bimanually to bring the occiput anterior. 2. Forceps (axis traction) may be applied to the head, preferably well flexed. 3. Podalic version may be done. When the bag of waters is unruptured, the first plan should be adopted. After the escape of the waters, this method should still be given a trial before the application of the forceps. For this operation, as well as for podalic version, ether should be administered. If the head passes the superior strait and the occiput turns into the hollow of the sacrum, efforts both manual and instrumental should be continued to bring the occiput anterior. This failing, then, as a last resort, the forceps may be applied to the persistently posterior occiput, and traction exerted until the small fontanel appears at the vulva, and the perineum slips back to the neck.

**Resumé:** Examine every pregnant woman before the advent of labor, and correct faulty positions, and in case the patient is not seen until labor has begun, endeavor to secure and maintain perfect flexion of the head throughout both first and second stages of the labor.

***Precocious Mothers.***—Journal of Surgery and Gynecology.—In February last we noted the fact that a girl ten years and two months of age had been delivered of a healthy child. Dr. T. J. Mitchell, of Locust Grove, Ga., has an almost equally young

mother—one who at the age of thirteen years was already the mother of three children! She first became a mother at the early age of eleven years, three months, and twenty-three days, and gave birth to twins at the age of thirteen years, one month, and fifteen days.

***Antistreptococcus Serum in Puerperal Fever.***—Dr. McKerron describes three cases of puerperal septic infection in which injections of serum were made. The first was a multipara who had a fever at the beginning of the second week. The uterus was large and soft, and a chill shortly afterward occurred. Serum was used in doses of 10 cm. A gradual fall of temperature occurred, and the patient recovered; three injections were given. The second case was that of a multipara who had a chill the second day after delivery. She had a bright rash upon the chest; she had a high temperature, abdominal distention, and scanty lochia. Four injections were without avail. The third case was a multipara attended by a midwife; the labor a breech presentation. On the fourth day after confinement headache and fever developed, and eight days after confinement serum was injected. Three injections were administered, causing pain and tenderness in the arm with an extensive erythema. Although the patient was threatened with inflammation of the breast, she ultimately recovered.

***Diet of Puerperal Women.***—Dr. Blau, Monatssch. für Geburtsh. und Gynakologie.—The author carried out a series of experiments by putting patients on different diets during their puerperium, and noting the effect on their metabolism. The kinds of diet employed were milk, eggs, meat, low mixed diet, and full mixed diet.

The urine was not changed in quantity by the different diets, but the specific gravity was slightly increased by the exclusive use of meat or eggs.

Involution of the uterus was hastened by the egg, meat, and full mixed diets, while the child lost less in weight on the milk, egg, and full diets.

The quantity of milk was greatest on the egg and full diets, but the percentage of fat was larger on a meat diet.

The mothers lost less in weight on the full diet.

From these results the author concludes that a full mixed diet is preferable in all cases of normal puerperium. After the third day the patient may take the same amount and same kind of food that any other healthy woman takes.

**Post-Partum Hemorrhage.**—N. E. Med. Month.—For a curative measure there is nothing equal to hot injections, made after the uterus has been thoroughly emptied. The promptest action is necessary. Ergotine may be used in combination with good results, but perchloride of iron is apt to stiffen the mucous membrane, causing adherent clots, which are very difficult to expel. Should the hemorrhage be very mild, friction over the fundus will often be of great assistance in exciting contractions of the uterus.

After the hemorrhage has been controlled, give stimulants, warm drinks, etc. Ligate all the limbs, in order to retain most of the blood of the body in the trunk. Transfusion of blood has been tried in cases of extreme exhaustion, but with not very flattering results. Artificial serum, in intravenous injections, has proved very useful.

**Eclampsia.**—At the recent Congress of Gynecology and Obstetrics at Geneva (Sem. Méd.), Charpentier said that when the patient was seized with eclampsia, and labor appeared spontaneously, all were agreed that the right treatment was to terminate labor as quickly as possible. But when eclampsia set in before labor a distinction must be made between cases at or nearly at term and those earlier in pregnancy. The German school consider the induction of premature labor, or even abortion or forced delivery, the only treatment. Dührssen incises the cervix deeply, and, if necessary, the vulva and perineum; Bossi uses instrumental, others manual dilatation; others, again, would resort to Cæsarean section. Charpentier is convinced that induction of labor is useless and forced delivery dangerous. He concludes that: (1) The urine of every pregnant woman should be examined. (2) If the least trace of albumin is found she must be put on a strict milk diet, which prevents the production of toxins; this must be continued till after labor and till no albumin is present. (3) When œdema without albuminuria is found the milk diet is indicated. (4) Whenever eclampsia occurs with cyanosis in a strong woman, bleeding up to half a liter must be performed.



(5) Chloral should be given. (6) When convulsions have set in, milk should be given by the mouth, or, if necessary, by the esophageal tube; this alone sometimes causes cessation of the convulsions. Besides this, the fits should be treated with chloroform inhalations, and diuresis induced by subcutaneous injections of normal saline solution. One must then wait till normal labor sets in. If there is inertia uteri, labor must be terminated by forceps or version if the child is alive, by basiotripsy if dead. Induced labor is only exceptionally necessary, and forced delivery never. Halbertsma, Mangiagalli, Bossi, Pasqualini, and others, spoke on the other, or "German" side, and advocated early emptying of the uterus, very favorable statistics being brought forward in support of this.

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## Gynecological Etchings.

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**Fetus Papyraceus.**—Dr. Bäcker (Centralbl. f. Gynäk.) recently demonstrated at Budapesth a fetus papyraceus. The mother was a primipara, aged twenty-eight, and was delivered at term of a well-developed female child, nearly 19 inches long, weighing 6 lbs. 12 ozs. On the placenta was the chorion, which bore a second amniotic cavity containing the fetus papyraceus. This blighted embryo appeared to have reached the second month of development. Bäcker preserved the membranes and the placenta as well as the fetus in a 4 per cent. solution of formaldehyde; they remained perfect, free from shrinking or opacity.

**Oophorectomy to Induce Menopause.**—Dr. A. Johnstone has found that a scrap of ovary left behind does not necessarily prevent the suppression of menstruation. If the ligature be close up to the horn of the uterus, so as to crush the sympathetic nerve as it goes into the uterus, there will be no further menstruation. In cases of retroversion Johnstone ties behind the round ligament, so as to bring it into the grip of the ligature. If a knuckle of the round ligament be thus included on each side, he feels sure that the patient will never menstruate, even if both ovaries are left untouched.

**Placenta Prævia.**—Dr. Baumm (Centralbl. f. Gynäkol.) recommends external version in placenta prævia, that, the presentation being converted into a pelvic one, the hemorrhage may be arrested by drawing down and keeping up traction on a foot. The version is generally possible, as the placenta prevents the early engagement of the head; after it has been performed, if the os is not sufficiently dilated to admit two fingers, one must, when bleeding begins, apply a tampon and wait; if the genitals are relaxed, it is generally easy, even without an anæsthetic, to bring down a foot and by moderate and steady traction to deliver the woman without further loss of blood. If the bleeding be severe and alarming, it is better to employ combined podalic version at once, or to apply a tampon before attempting external version.

**Nature's Method of Vaginal Antisepsis.**—Professor Lusk expresses himself as strongly opposed to the vaginal douche before and after parturition. While the vaginal canal abounds in micro-organisms, he considers that they only intensify the acid reaction of the vaginal secretions, and render the latter especially unfavorable to the multiplication of the streptococcus, which is the germ that produces puerperal septicæmia. The normal vaginal secretions furnish a soil hostile to all forms of cell growth. The cervical canal of the pregnant woman is protected from the invasion of micro-organisms by a mucous plug, and thus in natural labor the protection of the uterine cavity is complete. The entire parturient act, furthermore, serves to guard the woman against infection. With the rupture of the membranes the downward current is produced by the escape of amniotic fluid. The descent of the child cleanses the vaginal canal, and the associated leucocytosis and increase of vaginal secretion are inimical to the action of the septic germs. Finally, the passage of the placenta completes the toilet of the vagina.

The fact that nature provides this excellent means of self-defense clearly shows that the disturbing methods of disinfection employed before and after labor, under the plea of prophylaxis, are not commendable. The antiseptic douche dissolves the mucus, sets free the imprisoned germs, weakens the resistance of tissue, and contributes to the extension of the source of infection.

**Three Normal Pregnancies after Nephrectomy.**—To the cases already recorded by Schramm, Fritsch, and Israel, E. Tridondani (Ann. di Ostetricia e Ginecologia) adds an interesting instance of the reproductive history of a woman who had had a kidney removed. A patient, aged twenty-nine, came into the Maternity at Pavia suffering from symptoms resembling those of intestinal obstruction, accompanied by pain on micturition, and scanty urine. She was in the eighth month of pregnancy, and to the left side of the uterus was a fluctuating tumor. Under treatment the symptoms improved, and the woman was spontaneously delivered of a male infant. Three months later the abdomen was opened, and a cystic kidney (the left) was removed; the recovery was complete. Since then the patient has had three pregnancies. In none of the three were there any abnormal symptoms: no œdema, urine normal in quantity and quality. The labors were at the full term and non-instrumental. The placenta and membranes in each case were healthy, and the puerperium was normal. The infants were born alive, were healthy, and had a weight and size above the average. The author concludes from the study of this and other reported cases that pregnancy occurring in a woman with one kidney does not interfere with her health; that the absence of a kidney does not disturb the progress of gestation, labor, and the puerperium; and that the product of conception does not suffer. He does not, therefore, agree with Schramm, who advises a woman with a single kidney not to marry, or if married already not to become pregnant. It is noteworthy that in the above case the liquor amnii was increased in amount; but it is doubtful whether this was a consequence of the absence of one of the mother's kidneys.

**Deciduoma Malignum or Ectoplacental Epithelioma.**—Dr. Durante (Rev. Med. de la Suisse Romande) regards the tumor known most commonly as deciduoma malignum as a growth arising from the fetal ectoderm in its placental portion. It is a fetal epithelioma, originating either directly in the ectoplacenta or in the syncytium, which represents the remains of it in the placenta at full term. He gives a demonstration of the complete resemblance which exists between the histological characters of the ectoplacenta and those of the malign deciduoma. The

deciduoma may, indeed, be compared to a malignant return of the physiological ectoplacenta occurring sometimes during pregnancy, but more often developing later from débris of syncytium, contained either in moles or in placental polypi, grafted on, perhaps, more easily on account of modern obstetrical asepsis. The diagnosis is made from the history of repeated severe uterine hemorrhages, and from a careful intra-uterine examination of the tumor (which is soft and friable and attached to a thinned and softened part of the uterine wall) and a microscopic inspection of fragments of the growth. Its progress is rapid, cachexia soon appears, and death results either from the severe hemorrhages or from the frequently occurring metastases. The only effectual treatment is total hysterectomy, performed early; much valuable time is lost by repeated curettings. Operation ought to be preceded by a careful examination of the lungs in order to be assured of the absence of pulmonary metastases. Even in the cases in which a cure seems to follow operation, two years must be allowed to elapse before all danger of recurrence is past.

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## Pediatrics.

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*Chlorosis and Papillo-Retinitis.*—Dieballe (Deut. med. Woch.) describes a case in a girl, aged twenty-one, in which optic neuritis occurred in the course of chlorosis. She had first suffered from chlorosis when she was fourteen years old. Recently she had complained of severe headache and vertigo, but there was no vomiting. The menses were irregular. In March she had mistiness of vision, and, in reading, the letters appeared blurred. On admission (April 10) there was marked anæmia. The hemoglobin stood at 31, and the red blood cells at 3,880,000. The number of white cells was 7,200, and the specific gravity of the blood 1040. A papillo-retinitis was present on both sides, and there was slight paresis of the left abducens nerve. On April 20 vision in both eyes stood at  $\frac{1}{4}$ . The right papilla was grayish red and swollen, the outlines of the disk being very blurred. The veins were wide, the arteries narrow, and the vessels in places

covered with exudation. The left disk showed similar changes. In May the neuritis was much less marked, and in September the patient was quite well. The body weight had increased 4 kilog. The hemoglobin stood at 75, the number of red cells at 4,200,000, the white cells at 5000, and the specific gravity was 1055. The fundus oculi was quite normal. The neuritis was undoubtedly caused by the chlorosis, all other causes having been excluded. Such a complication of chlorosis is exceedingly rare. The explanation is still quite hypothetical. Sometimes loss of blood produces disturbance of sight due to a neuro-retinitis. In the above-named case overexertion (dancing) had made the chlorosis suddenly worse. Shortly after this overexertion menstruation reappeared, and the author assigns the neuritis to these two deglobulizing factors. The intense headache in this case along with the neuritis suggested the possibility of a cerebral tumor. Rest and iron treatment, however, soon caused the headache to disappear.

**Menorrhagia in Virgins.**—Dr. Laroyenne (Lyon Medical) distinguishes the majority of cases of profuse menstruation in young girls which require no local treatment from a minority in which the use of the curette is advisable. If, after long attention to hygiene and a course of suitable tonics, menorrhagia persists, interrupted by occasional amenorrhoea, granular or fungous endometritis probably exists. This disease is still more safely diagnosticated when the patient has been perfectly healthy and quite free from anæmia before profuse menorrhagia appeared, and equally free from evidence of diseased appendages after the local symptoms became marked. It is right after dilatation to use the curette when the excessive menstruation causes debility. A single application of cotton wool, soaked in equal parts of water and chloride of zinc, made immediately after the scraping, is sufficient. Repeated cauterizations may readily cause atresia.

**Diphtheria and Scarlet Fever.**—Dr. Joy, Brit. Med. Jour.—The following case affords an instance in which there was no question of exposure to more than one infection. This case, occurring under other circumstances, would undoubtedly have been regarded as diphtheria. Two children residing in the same farmhouse contracted scarlatina at their school, and were at once brought home; they presented typical examples of the disease,

with erythematous sore throat, bright and well-marked rash, strawberry tongue, high temperature, and albuminuria. Their little sister, who had not been away from home, took infection from them, sickening within a week from their return. This child displayed, from the commencement of her illness, considerable swelling of the cervical and submaxillary glands, accompanied by great prostration, and before long the tonsils, uvula, and cheeks were found to be covered thickly with false membrane. Were these symptoms due to the working of two distinct and separate poisons, or were they due to the poison of scarlatina?

Dr. Greenhow quotes a case recorded by Chavasse of typical diphtheria (occurring in the house with two cases of scarlatina) in which no subsequent desquamation took place, and no rash was present. The well-known group recorded by Dr. Duncalf, of West Bromwich, is still more striking. A man was attacked on October 1 with sore throat; the tonsils, uvula, and pharynx were thickly covered with false membrane, leaving a red and abraded surface when detached, and attended by collapse and a pulse which sunk to 60. On October 7 a child, an inmate of the house, was attacked by scarlatina, followed by desquamation and anasarca. On October 13 a sister of the first patient, residing two miles away but visiting her brother in his illness, was attacked in her turn by scarlatina, took the infection to her home, where another brother soon developed what seemed to be diphtheria, having a sore throat accompanied by widely distributed false membrane, and attended by much prostration. Perhaps our belief in the "pathological independence" of the two diseases is stronger than ever to-day, but if cases such as that to which attention was called were more frequently recorded, possibly we should eventually find cause to alter our opinion.

**Paralysis After Mumps.**—Dr. Revilliod (Rev. Med. de la Suisse) describes a case where, directly after an attack of mumps, a boy, aged seven, became paralyzed. Weakness of the legs was first noticed, and this was followed by dysphagia and rapid emaciation. The legs could be slightly moved, but he could not stand. There was left facial paralysis. Both eyes could be shut together, but the left not alone. The tongue could be scarcely protruded as far as the lips, and deviated to the right, but there was no atrophy. The movements of the palate were sluggish.

Swallowing was almost impossible, and liquids swallowed brought on a paralytic cough, so that feeding with the tube was necessary. Respiration was labored and sighing. All four limbs were equally affected. The sphincters, special senses, general sensation, and the vasomotor system were intact. Faradic excitability of the left facial was diminished. Galvanism caused great pain, but no contraction. The cranial nerves involved were: the sixth on both sides, the left facial, the right hypoglossal, the external division of the spinal accessories to the neck, and the internal (recurrent) branches. Diagnosis: Infantile paralysis could be excluded and diphtheritic paralysis was disproved. There had been no case of diphtheria in the commune for five years; the boy's throat had been examined when the mumps began, and no signs of diphtheria were present; his brothers and sisters all had mumps about the same time. Only one other case has been reported.

*Paralysis of Child's Arm After Delivery by Feet.*—Dr. Guillemot (Annales de Gynéc. et d'Obstet.) publishes a report of a large number of cases of paralysis of the arm, where all the infants were extracted by the feet and all by the same midwife. Prouff, of Morlaix, detected nearly thirty of these cases, Guillemot publishing clinical notes of twelve out of the same series. Most of the patients were about twenty years old, for the cases have been most carefully watched. In many the shoulder-joint, elbow-joint, or wrist was the seat of disease, not neuropathic, but, like the nerve lesion, caused by damage during delivery. The midwife must have pulled with great force and very irregularly, knowing nothing about axes. Guillemot suspects that she in several instances turned, probably when quite unnecessary, and extracted before complete dilatation of the os. He gives reasons to show that the paralysis was not due to myelitis. Torticollis was present in some cases, but Guillemot admits that it might be a complication caused by laceration of the sterno-mastoid muscle and hematoma or by articular disease in the cervical spine. In nearly all the scapula on the affected side was elevated, indicating paralysis of the lower part of the trapezius. The branch of the cervical plexus which supplies this part must manifestly be stretched by the great depression of the shoulder caused by firm and prolonged traction on the arm. These tractions appear to

damage the fifth and sixth cervical nerves most severely, judging from the lesions seen in the arm. When the cervical spine is torn through or the head torn off in delivery, the separation occurs at the level of the third, fourth, and fifth cervical vertebræ. Thus, at this level the tissues are least resistant and allow of the greatest amount of traction. In these cases sensation is usually preserved more or less, for during these violent and clumsy tractions on the arm the head is deflected and the neck forms a concavity backward, so that the posterior and sensory roots of the cervical nerves suffer the least traction.

*The Joint Affections of Scarlet Fever.*—Dr. Marsden.—Nearly all the specific fevers, including pneumonia, may be followed by some form of inflammation of a joint structure, and yet we have very little accurate knowledge as to its actual origin. The joint affections of scarlet fever afford a good field for investigation, because there is every reason to believe that several varieties occur, each variety probably depending on a different materies morbi. He adopts the following classification: (1) Scarlatinal synovitis; (2) septic arthritis, acute and chronic; (3) acute and subacute rheumatic synovitis; (4) tubercular arthritis.

The first form of synovitis is marked off distinctly as being at any rate not of a rheumatic origin, and many facts are adduced to support the separation. This, which is the most common form of joint affection, occurs in about seven per cent. of all cases of scarlet fever—at any rate, in hospital practice. It is very constant in the date of its appearance, the great majority of instances occurring from the fourth to the tenth day of the disease—in other words, during the defervescence of the fever, or shortly afterward. Its site also is very constant, the wrists being affected in seventy-two out of one hundred cases. The common localized swelling is on the back of the hand, due apparently to affection of the sheaths of the extensor tendons, and sometimes also of the synovial membranes of the joints.

It seems to have no connection either with the severity of the throat affection or with the occurrence of desquamation; and from the regularity of its occurrence at a definite early point in the illness, and from the absence of any evidence pointing to connection with rheumatism, and from the common situation of the swelling, it seems probable that it is actually a part of the disease, due directly to the scarlatinal poison.



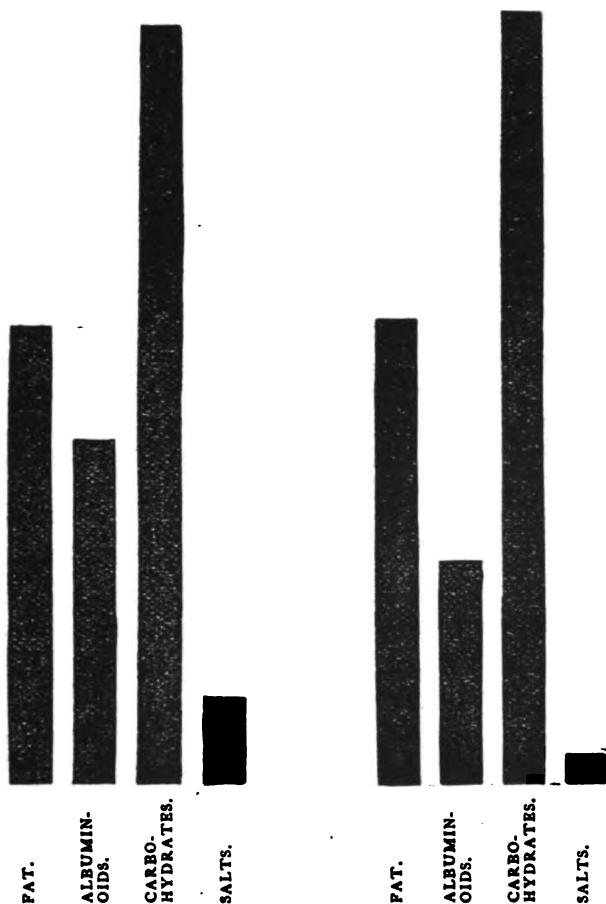
As regards the other forms of joint affections, the evidence adduced assigns to them a non-scarlatinal origin. The septic form, which only occurs in about 0.75 of all cases, is clearly connected with the severity of the throat affection, and it is probably due to a mixed infection. It is attended with a high rate of mortality. The form of synovitis, which may with some probability be looked upon as rheumatic, is still less common, and it does not occur until an advanced stage of convalescence is reached. The tuberculous form usually appears only after the discharge of the patient, and the preceding scarlet fever probably acts as a predisposing influence.

A much rarer phenomenon in scarlet fever is the occurrence of orchitis. Some few cases have been placed on record where this complication has occurred in the second or third week of the disease, and they are probably to be explained on the hypothesis of a mixed infection arising from the throat. A curious instance is detailed by Faugere, in which a man developed an acute orchitis some thirty-six hours before the onset of scarlet fever without any possibility of attributing it to any of the ordinary causes. It quickly subsided, but reappeared again with the commencement of desquamation, and lasted for several days.

***Etiology of Follicular Enteritis in Children.***—Dr. Finkelshtein (Deut. med. Woch.) states that it is universally admitted that the majority of cases of gastro-intestinal enteritis are due to an infection. The source of the contagion lies in the stools. Two groups of the disease are to be distinguished—the dysenteric and the toxic. The actual cause of the disease must therefore be able to give rise to irritation of the mucous membrane, and to produce toxic products. The bacteriological examination of the purulent masses in the author's cases showed the presence of abundant rod-like micro-organisms contained in the pus cells, and varying much in appearance. Often they were arranged in twos. All the different forms were shown to belong to a single micro-organism. By cultivation, a microbe possessing extraordinary resemblances to the *B. coli communis* in almost pure culture was obtained. The author then details his inoculation experiments. In mice it produced, when introduced with the food, a disease very like Loeffler's mouse typhoid. The morbid appearances corresponded exactly to those described by Heubner as taking place in the epithelium in cholera infantum, but ulcerative processes were absent. The micro-organism is only present in the glands, and hence the death of the epithelium must be due to a toxic action.

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Fig. XVII—Dorsal Position.

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## OBSTETRICS.\*

BY SHELDON LEAVITT, M. D.

WE congratulate ourselves and patients on the remarkable advances which have been made in surgery and obstetrics within the past generation, and we have most excellent reason for so doing. Innovations, to be sure, are not always improvements; but we are confirmed in our convictions of the utility of the changes wrought in obstetrical theory and practice by the logic of vastly diminished mortality and morbidity among patients of this class. Fatal hemorrhages, either before or after delivery, are now rare; vesico- and recto-vaginal fistulæ are seldom met; vaginal relaxation and prolapse, as the result of unrepaired lacerations, are not so frequent; complete perineal ruptures are unknown in the practice of many; and even imperfect uterine involution is less common than it once was; while convalescence after lying-in comes closer to the ideal form than it formerly did.

\* Sectional Address made before the American Institute of Homeopathy, June, 1897.

Though these truths are patent to every rational investigator, there are a few physicians in every populous community who openly sigh for "the flesh pots of Egypt"; while there are many others, embracing all shades of therapeutic practice and all degrees of medical learning, who are slow to adopt the newer methods of management, content to plod along with the old, giving vent to their aversion in cries of "meddlesome midwifery," "unnecessary interference," "surgical craze," "new fad," and the like.

That there are some who assume this attitude toward improvements of the utmost value to suffering femininity is to be expected, and yet that they do so is a cause for profound regret. But this not the only class of obstetric practitioners who block the wheels of progress. Even among those who count themselves enterprising and liberal there are those who hold to inimical precepts and practices.

I cannot hope in an address of this character to go over the ground in critical detail; but I would count myself recreant to a solemn obligation were I to keep silent in the face of the professional wrong-doing which has fallen under my observation as a consulting obstetrician, and which, I assume, is far more prevalent than many suppose.

*Inadequate Surveillance of Pregnant Women.*—Our oversight of women during gravidity ought to be more thorough than it usually is. I admit that conditions are unfriendly to strict surveillance. Few women can be made to feel the need of it, and, should normal conditions prevail, in a given case, after a brief period of exact supervision reluctantly granted and for a while exercised, both doctor and patient are liable to lapse into neglect. It is lamentably true that there are far too many cases of serious disturbance during pregnancy arising as a surprise to both patient and physician, which had been preceded by the usual, but unobserved, prodromata, and which, had the patient been kept under care, might have been arrested in their incipency.

*Inadequate Preparation (a) of Patient, (b) of Physician.*—

This has a major reference to the asepsis which should be approximated in all obstetric cases. I say "approximated," because I am well aware that fecundity and filth approach the value of synonyms in some of our modern communities, and that true cleanliness, in certain families, if not in all, is necessarily a relative condition. But there are many accoucheurs (I say it with shame) who do not understand the significance of the term "cleanliness," and who will not be clean when they may. Instructors ought to be highly dogmatic with regard to these matters, and insist that he who will not be clean should not practice. Soap and water can everywhere be had, and they should not be used any the less sparingly in obstetric than in surgical practice. Uncleanliness of person, of clothing, of bed, of instruments, and of surroundings is not to be tolerated. The cleanest that the house can afford should be insisted on as the natural right of the parturient woman.

Besides these matters, the term "preliminary preparations" has reference also to the preparations which the physician should make in the way of possible requirements for emergencies. The obstetric bag of a well-equipped obstetrician is supposed to contain everything which may be required for the proper treatment of complications, whether demanding the performance of catheterism or of Cæsarean section. To be sure there are many doing a large midwifery practice who are qualified and equipped to manage those cases only which pursue a relatively normal course, and who depend upon the assistance of their confrères, when, by a combination of unusual conditions, their patients are placed in jeopardy. Such helplessness ought not to exist, and I predict that it will ultimately become a rare exception, instead of a prevalent weakness.

*Non-recognition of Presentation and Position.*—Skill in the recognition of fetal relations to the maternal pelvis does not proceed alone from extensive practice, as I have demonstrated in many instances. The accoucheur who is familiar



with the anatomy of the infant, and the pelvic anatomy of the female, may soon learn, from a careful study of his cases, how to detect both presentation and position with comparative ease; while the unlearned or inattentive, no matter how experienced, will ever remain sadly deficient as an obstetric diagnostician.

As in the management of pathological conditions generally we find many who depreciate the value of exact diagnosis, so here there are those who follow a like course; but if we would be practitioners worthy of professional and lay confidence, let us frown upon conduct of this nature, and insist upon regarding it merely as a confession of incompetency.

*Too Early Interference.*—The busy physician is liable to become impatient when labor drags, and in consequence is often betrayed into precipitate action in his management of it. No serious harm is likely to follow parturition which is slow in the first stage, unless the delay be sufficient to bring profound exhaustion. In this respect the first and last stage are quite dissimilar, for in the latter, delay is inimical to both fetal and maternal interests, and ought not to be tolerated. It is true that certain exigencies sometimes arise which imperatively call for immediate delivery, even when the os uteri is but slightly expanded or is entirely closed; but to such cases I do not now allude, reference being had only to those which present no strictly abnormal or unusual features save the one of protraction.

I need not pause to consider the ætiology of delay in the first stage. The causes are various, and commonly there is a slight disproportion between the fetal and maternal diameters, though this is not sufficiently pronounced to constitute an actual abnormality. Again the cause is found in advanced ossification of the fetal cranium.

Now such cases, if committed to the natural efforts for a sufficient time, will ultimately terminate without instrumental aid, or will advance to a degree which will insure

comparatively easy extraction. On the other hand, if the accoucheur is driven by his own impatience, or by the persuasive appeals of his patient, to undertake forceps delivery at an earlier period, while he may succeed, he is likely to do so at the expense of great effort, destruction of fetal life, and much maternal contusion and laceration. I have so often seen this error in management that I cannot refrain from raising my voice against it.

*Too Tardy Interference.*—Premature application of the forceps is an error which clings chiefly to the inexperienced and timid. The expectant plan of treatment is common to old-fashioned physicians, who do not take kindly to modern methods, which to them have a flavor of recklessness. There is a golden mean between these extremes, which the wise accoucheur should aim to follow.

*Improper Use of Instruments.*—(A) The placental forceps, once an instrument regarded as indispensable to proper uterine evacuation in a case of retained secundines in abortion, has been entirely superseded by the curette. The same may be said of the placenta hook. Neither instrument was over well-suited to the purpose for which it was designed.

(B) The curette is now in vogue; but it is often improperly used. A good curettage cannot be made, save on women possessing great fortitude, without an anæsthetic; it cannot be satisfactorily done without putting the patient into a favorable position; nor can it be safely undertaken without strict regard to asepsis; yet all these essentials are frequently ignored.

(C) The obstetric forceps, even when used at the proper moment, is often improperly applied. The accoucheur would do well to remember that the instrument, when applied at the brim, should embrace the head in such a manner that the blades will lie squarely in the sides of the pelvis (pelvic mode). The result is that usually the head is seized over the poles of an oblique diameter. If the occiput lies posteriorly, the forceps would better be removed

and then reapplied during the progress of delivery, so as ultimately to bring the occiput to the pubic arch without inversion of the instrument.

When the head lies in the pelvic cavity or at the outlet, the blades should be so adjusted as to embrace it over the poles of the transverse (bi-parietal) diameter (cephalic mode). Should the occiput lie posteriorly, a double application is advisable, as in the other instance, so as to bring the occiput to the pubic arch without inverting the instrumental curve.

Too rapid delivery is often made. In the absence of urgent symptoms enough time is to be given to avoid overstrain of the soft tissue.

*Inattention to Injuries.*—Immediate suturing of parturient lacerations is an operation no longer on probation. In my opinion there is not the slightest question of advisability of it, and no physician ought to practice obstetrics who is not competent to do a vaginal and perineal operation.

*Inadequate Repair of Parturient Injuries, and Inattention to the Wound after Suturing.*—Simple shallow rents, which can easily be gotten at, furnish no problems concerning methods of repair; but this is not true of deep and extensive lacerations of the soft structures which form the pelvic floor. The purpose of this paper is to mention faults and defects rather than to give the details of correct treatment, and accordingly I shall not here describe what I deem the best methods of repairing these injuries. That the suturing done by the average practitioner is in many instances faulty and ineffective, I am sure. I have seen some perineæ, one in which attempts at repair had been made, which might far better have been left to gape. To summarize the causes of failures, I should say that imperfect results are obtained because of defective technique. For example, the vaginal end of the wound is often let slightly agape, so that the lochia soon penetrate the full length of the wound. But there are many cases which are well sutured, and in

which every primary condition of success is fully met that still prove disappointing in results. Let me suggest that such failures are sometimes due to inattentive after treatment. A wound of the perineum is exposed to peculiarly unfavorable conditions, owing to the lochial discharges, which flow over it day and night, and to the deleterious production of disintegration. Still, much can be done by an attentive nurse in the way of protection. Frequent careful sponging away of the moisture, by means of small pledgets of absorbent cotton, and a liberal application of boric acid, serve a most helpful purpose. Attentions of this nature are of course made to include the vaginal, as well as the integumental, surfaces. I sometimes employ gauze drainage in the vagina, just as I would in a wound cavity, with frequent but careful changes.

*Unwise Treatment of Puerperal Conditions.*—Serious errors are often made in the treatment of mammary engorgement. Nurses are disposed to be overactive in their desire to relieve the “cakes” which accompany and characterize a free incoming of the lacteal secretion. Much rubbing is harmful. The fact is not generally known that there is really slight danger of inflammatory action at such a time, even though the patient be subjected to expectant treatment. But when, in any case, threatening symptoms arise, very hot fomentations, faithfully followed up, aided by the indicated remedy and careful emptying of the breasts, will afford perfect relief.

Vaginal douching is no longer in vogue. The vagina is washed out soon after delivery, and then is left undisturbed until such time as the lochia become fetid, as they usually do, to a certain degree, four or five days *post-partum*. Then one or two douches a day are given as long as required. The chief objection to the vaginal douche is found in the danger of infection accompanying its use. There is no doubt that unclean syringes and filthy hands have sent many puerperal women to their graves. When

properly used, I still regard it as an element of considerable importance in the direction of prophylaxis; but unfortunately, few nurses can be trusted to administer it.

On the other hand the uterine douche has come into vogue, and we find in it vast possibilities of good. At the same time I want to sound a note of alarm, for I have seen it do positive harm. The cavity of a puerperal uterus is not to be invaded upon the slightest pretext; nor is it, in any event, to be entered without due precaution. A puerperal woman suffers a chill. "This," argues the attending physician, "must be due to effete matter in the uterus, which I will proceed to wash away." Accordingly he prepares an old syringe by loading it with an antiseptic solution, and after a struggle on his part, and many cries on the part of his patient, he succeeds in getting a certain amount of the solution into the uterine cavity. It may be that the patient's temperature drops for a time; but how much real good has been accomplished? and, again, how much mischief has been done?

Let me formulate the following axioms: (1) the uterine douche is not to be employed unless one has good reason to believe that the symptoms proceed from infection which has its origin in the uterine cavity; (2) it is not to be employed except under strict aseptic conditions; (3) it is not to be undertaken with the patient in an unfavorable position; and, finally, (4) it is never to be used without making sure of adequate escape of the solution as it is injected.

What I have said of the intra-uterine douche applies in a measure to the curette: (1) it is never to be used, save for good and sufficient reasons; (2) never without strict observance of asepsis; (3) never without putting the patient into a favorable position; (4) never with force, and yet never without thoroughness; and (5) rarely without an anæsthetic.

In conclusion allow me to express a conviction that the

day is not distant when the pregnant woman of intelligence will select her attendant with far greater care, and require in him qualifications for meeting any obstetric emergency which is liable to arise. For one, I believe that obstetric practice in populous communities ought either to be established as a distinct specialty, or the qualifications of those who undertake it speedily brought to a much higher level.

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### HEART DISEASE AS A COMPLICATION OF PREGNANCY AND PARTURITION.\*

BY L. L. DANFORTH, M. D.

THIS subject having been brought to my attention during the past few years under circumstances of great anxiety and peril, I turned to the library for help ; but much to my dismay found that Lusk, Parvin, Winckel, Leavitt, Charpentier, Cazeaux and "The American System of Obstetrics" gave very little that could serve in cases of this kind ; the the majority of writers contented themselves with general statements regarding the maternal blood, the tendency to hypertrophy of the left ventricle, and the relative frequency of the different heart lesions. The symptomatology of heart disease as modified by pregnancy is lightly touched upon, and either nothing is said about treatment or the statement is made that the treatment applicable to heart disease under ordinary circumstances will suffice when pregnancy is added thereto.

It is well known that the condition of the blood, especially in the latter half of pregnancy, is more watery, contains fewer red corpuscles and less hemoglobin than in the healthy non-pregnant state, but with an excess of fibrin and white blood corpuscles ; so there is a relative anæmia ;

\* Abstract of paper presented to American Institute of Homeopathy, Buffalo, 1897.

this is most likely to occur in women who are delicate or have borne children rapidly, or in those who have suffered intensely from gastric disturbances. It is in cases where blood alterations are present and the heart's action pronounced that the most favorable condition exists for real hypertrophy of the walls of the left ventricle.

The extra burden thrown upon the heart in the maintenance of the fetus is an important factor in hypertrophy. Barnes enunciated a great truth when he said: "Since in pregnancy every organ and the whole organism are especially weighted, undergoing extraordinary development and functional activity, so any defect or fault inherited or acquired, however latent, will be liable to be evolved or intensified under the trial. Hence, pregnancy is the great test of bodily soundness."

CASE I. Mrs. M., multipara, æt. twenty-eight, mother of two children. In beginning of eighth month in both pregnancies suffered from dyspnœa, palpitation, cerebral congestion, and cough. Both labors ended favorably. In third pregnancy there was found marked mitral murmur. In the beginning of the eighth month of last pregnancy the same dyspnœa occurred as in the former pregnancies, with most distressing oppression over the heart, cyanotic face, pulse weak and rapid. This occurred once or twice a week during remainder of term. Digitalis, cactus, glonoine, and amyl nitrite gave relief. Labor finally began; waters broke when os dilated size of a quarter. Gels. and hot water injections promoted subsequent dilatation. Small boy born. Made quick recovery and murmur disappeared. Doubtlessly this was a functional disorder.

Fatty degeneration of the muscular structure of the heart is apt to be found in women who have had repeated pregnancies, and who are poorly nourished, and these may result in sudden death during or shortly after labor. Barnes refers to several such cases.

CASE II. Patient thirty-eight years old, with eighth

child. Limbs œdematous to knees, pulse 110, feeble and intermittent; heart weak, faint murmur audible with first sound. No albumin or casts. Patient always in good health; married at twenty-four and pregnant soon after. Has been either carrying baby *in utero* or nursing one ever since. Menses have never occurred but once after each labor. Troubled with cough during pregnancy. First four labors normal. Fifth was preceded by escape of amniotic fluid; while being bandaged after the birth of the child fainted and was unconscious for a long time. After sixth and seventh confinements nearly lost consciousness; could not move her head for fear of syncope. Still the eighth labor was completed without difficulty and made a rapid recovery. Here also the murmur disappeared.

Pregnant women with functional heart diseases are less likely to suffer the severe symptoms which accompany organic affections; so that treatment directed to cardiac weakness will prove eminently satisfactory. They are liable to suffer from syncope during and after the third stage of labor, and *post-partum* hemorrhage is likely to occur because of imperfect retraction of the uterus. Sometimes a distinct murmur is found at the apex; in other cases nothing is observed but weakness during the systole.

Mitral stenosis is more likely to result in pulmonary congestion and stasis of the right side of the heart than mitral insufficiency; then there is a tendency to overloading of the pulmonary vessels; mitral stenosis is not so likely to be compensated for by a corresponding hypertrophy of the right ventricle. In the latter months, when the uterus presses upon the efferent vessels of the kidneys, the urine becomes scanty and albuminous and may contain hyaline and blood casts. The tolerance with which women bear lesions of the mitral valve differs greatly according to the degree of compensation which has already taken place in the affected organ.



CASE III. Primipara, æt. twenty-four, with marked mitral lesion, but with ample compensation, got through first pregnancy all right, but child died soon after birth. Mother became pregnant again, and thirteen months after first birth had twin girls. This confinement ended without accident, and mother has had no further children.

Compensation of the valvular defect may be good at the time of marriage, but later the heart may not be able to bear the additional strain of pregnancy, and the failure of compensation may especially occur during latter half of pregnancy; in such cases everything depends upon the strength of the cardiac muscle. In proportion as the compensation fails the patient will suffer from dyspnœa with more or less embarrassment in the whole circulation.

CASE IV. Called in consultation to a lady pregnant for first time, and now advanced to eighth month. Father died of Bright's disease, and mother of organic heart trouble. Swelling of extremities and labiæ first arrested attending physician's attention. There was albumin and casts; urine scanty. At first kidneys thought to be at fault; examination showed marked regurgitant murmur with hypertrophy, and tricuspid insufficiency and enlargement of the right heart. Lungs œdematous, patient dyspnœic, cough, and cyanosis. Tr. digitalis, sambucus, and tartar emet. gave relief and increased urine. Labor two weeks premature, but successful.

CASE V. Lady pregnant for second time arrived at ninth month of gestation, œdematous and dyspnœic; small quantity of urine, with albumin and hyaline casts. Put on skim milk diet, bowels kept open, and hot baths prescribed. As labor progressed the congestion of the head became more marked during each uterine contraction. Patient was told to be as passive as possible; artificial breaking of membranes was followed by relief to the breathing. Made good recovery, although troubled for a long time with bronchitis.

In all cases of valvular disease complicating pregnancy, the kidneys are liable to become congested and albumin and casts appear, and there will be scanty and high-colored urine, hence there will be nervous symptoms in addition to dyspnœa. Be careful about diagnosis in all these cases. Every organ in the body should be interrogated.

In analyzing some of the symptoms likely to be met in pregnancy complicated with heart affections, I find that sudden attacks of dyspnœa are observed when the disease affects the aortic valve. Mitral insufficiency may be attended by persistent dyspnœa with heaving chest walls, because of forcible pulsations of the heart. Cardiac hypertrophy is greatly intensified during pregnancy. Added to these œdema of lower extremities, ascites and œdema of the lungs out of all proportion to any influence which pressure of the gravid uterus alone can produce as a cause of these symptoms; while the increased arterial tension is not apt to cause hæmoptysis. Pulmonary congestion may be general, or especially in the left lung. General bronchitis may be established as a result of obstruction to the pulmonary circulation, there also may be a distressing cough, with bluish lips. In pronounced cardiac affections the end of gestation is apt to come too soon. If it goes to the latter months it may terminate at any moment by the onset of pulmonary congestion. It is also likely to produce abortions.

Murray has many times seen miscarriages with none or but slight physical or mental shock as an exciting cause; and in quite a large proportion of miscarriages he had attended he had found heart trouble as the frequent cause. He noted the easy detachment of the placenta; *post-partum* hemorrhages frequently occurred; but in only one instance had it proved alarming. In this case it was controlled by digitalis hypodermically, and ergot by the mouth.

Albumin is generally caused by congestion of the renal

vessels resulting from impediment to the circulation through the heart, and is venous in origin. In mitral disease there is a constant tendency to pulmonary congestion, and as a result we observe dyspnœa, cyanosis, and congestion of the kidneys.

The following case is a marked example of pulmonary and renal congestion due to heart disease: Lady, æt. twenty-five, married four years. First seen October 5, 1893. Examination showed anæmia, pulmonary râles, dry hacking cough, marked mitral insufficiency, vertigo, dyspnœa, and general debility. Last menses June 29, 1893. Gave ars. and cod liver oil. But patient grew steadily worse. I was called in consultation January 7, and advised digitalis infusion t. i. d. and ant. tart. with strychnia 1-60 grains as required. The propriety of inducing premature labor was decided negatively until after the seventh month, if the patient's condition would permit. Notwithstanding an increase in the dose of digitalis the symptoms became gradually more pronounced; œdema enormous, dyspnœa severe, pulse feeble, urine almost suppressed, albumin heavy, twitching and suffocation during sleep. On January 25 seven months' labor was induced—a puny baby born, which died in two weeks. Mother was weak, and without apparent cause relapsed into a dangerous condition, but presently rallied and ultimately recovered her original ground. Her treatment during convalescence was the infusion of digitalis (every two hours at first—then gradually decreasing) together with strychn. sulph. (3-60 grains four times daily, increased gradually to 1-30; then gradually decreased to 1-60). She keeps both these drugs on hand now, and takes them when she seems to require them. At the time the labor was induced she was in a desperate condition, and her life was doubtlessly saved by the interference.

As to treatment: weak and enfeebled women may present during pregnancy symptoms and conditions precisely

resembling those of organic heart disease. Such cases usually terminate favorably, though dangerous symptoms may arise during labor and afterward from syncope and *post-partum* hemorrhage. Nutrition, diet, remedies addressed to the flagging heart, and care to insure a thorough retraction of the uterus after delivery are all that is necessary. Again, women with marked organic diseases will go through pregnancy with no symptoms whatever attributable to heart lesions. Such patients should be watched. A moderate bronchitis may be the starting point of sudden heart failure. In view of this, a moderate heart lesion in a young woman about to marry should prove no barrier to her wishes.

The necessity for the induction of abortion sometimes comes up for consideration ; this will be the case when there is marked mitral murmur with dyspnœa, albuminuria, and pulmonary engorgement. Our remedies will do much toward carrying a patient past the dangers which threaten.

Digitalis is not without its dangers ; in simple weak heart or where compensation fails in organic disease, it is of great benefit either in tincture or fresh infusion. But when the balance is lost, and the right heart has given out, it is not so useful. Its power to stimulate the uterus to contraction should be remembered. Other remedies are cactus, lachesis, tartar emet., and sambucus. For renal congestion we may think of apis, cantharis, helonias, and terebinth ; also glonoine and amyl nit. Strych. should not be overlooked. Rest in bed is often necessary ; good food and avoidance of constipation are very essential.

As to anæsthetics during labor : ether is a well-known heart tonic, but if there be an existing bronchitis and renal congestion it must not be used. Chloroform is interdicted in bad heart. The A. C. E. mixture may be used to advantage, when delivery by forceps is necessary, to mitigate the pain and lessen the shock. The objections to ether and chloroform are in a measure overcome by the

addition of alcohol. Ergot should be used with caution when the kidneys are affected.

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## IS THE INDUCTION OF LABOR JUSTIFIABLE IN PROTRACTED GESTATION? \*

BY GEORGE R. SOUTHWICK, M. D.

**M**OST experienced practitioners remember cases of difficult labor where the overgrown child was delivered dead and the mother barely escaped with her life, together with severe traumatic injuries. The possible duration of gestation is still in doubt. The courts of this country have decided judicially that pregnancy may last 317 days, that is, a possible variation of 37 days beyond 280. Winckel states that 5010 pregnant women were over 302 days in 47 cases, and over 300 days in 70 cases. There were 1720 women who could tell exactly the day of fruitful cohabitation, and in 117 of these pregnancies lasted over 300 days, or 6.8 per cent. of the cases. It is fair to assume that in a larger proportion of cases than is generally known, a woman may carry a child *in utero* for some days after it has fully developed and matured. Such child, though mature and physically ready for extra-uterine life, is retained *in utero* at the mother's expense. For while it is growing larger every day, the pelvis through which it must pass remains the same size. It must not be forgotten that an overdistended uterus is likely to be more deficient in contractile power than in premature labor. Therefore we have a lower rate of mortality for children when labor is induced at full term in a normal pelvis than when it is induced prematurely in a contracted pelvis, and the mother is spared the trau-

\* Abstract of paper presented to American Institute of Homeopathy, Buffalo, 1897.

matism and suffering of a very protracted labor, with correspondingly better chances for herself.

It has been assumed that a child carried beyond 280 days will be large in proportion to the pelvis; this is admitted up to a certain period; but after a child is once mature its growth is rapid, and the consequent changes have an important influence on labor. We have all had cases of dystocia where it was not the mere size of the head which made the trouble but its ossification and the firmly united sutures which prevented the head from molding in the pelvis. The accoucheur dreads those hard heads, firmly united sutures, and small fontanels. A fair idea of the intra-uterine growth of the child is obtained by observing the extra-uterine development. The change in habitat and nutrition arrests growth for the first week, so that this period should not be counted; but at the end of the third week after birth, which would correspond with 394 days of pregnancy, observe and measure the remarkable changes of the head as compared with the day of birth, the increased breadth of the shoulders, the density of the head and especially the very marked increase of its transverse diameters, which are noteworthy, as these diameters are in contact with the pelvic walls in labor and offer no little resistance. Think how much greater the difficulty of labor had that baby to go through the same pelvis from which it was born three weeks previously, and how impossible it would seem were the baby four weeks old, or corresponding to 301 days of gestation; yet carefully compiled statistics show that this is just what happens in 6.8 per cent. of our cases.

What shall we learn from contracted pelves? Symphyseotomy, the induction of premature labor, or a combination of both, Cæsarean section, and craniotomy have each its indications. The principle of election and the use of asepsis make it possible to select a relatively safe method of delivery. But this means examination of the mother in

the eighth month or earlier. Thus we will obviate that horror of obstetrics—craniotomy. Fehling has said that the danger to the mother from inducing premature labor as compared to Cæsarean section is almost nothing. Symphyseotomy before the days of asepsis showed an average mortality of thirty-three per cent. for the children and five per cent. for the mother. Labor induced after the thirty-sixth week was reduced from an average of all cases of thirty-three per cent. to fifteen per cent. Asepsis has now reduced it to almost nothing. Symphyseotomy is a most valuable aid to induced labor at full term, because it may enable us to deliver a living child, and especially where there is marked disproportion between the pelvis and child.

The statistics of protracted gestation resemble closely those of minor contraction of the pelvis. Bushbeck reports 491 cases of premature labor in deformed pelvis with a fetal mortality of 17 per cent. and a maternal mortality of 2.4 per cent. At the Halle polyclinic there were 308 cases, with a mortality of 12 per cent. for infants and 1.3 per cent. for the mothers. In comparison with this mortality that of induced labor at full term by antiseptic methods and as an operation of election should not exceed half of one per cent. for the mothers nor much more than the common average of fetal mortality.

Can such disproportion be recognized in time for successful treatment? While we can by practice obtain fairly accurate measurements of the pelvis, how can we find the size of the child? Ahlfeldt's pelvimeter and his table showing the weight of the child is very valuable; but Mueller's rule is fairly practicable for the general practitioner: premature labor may be deferred while the largest circumference of the fetal head passes the plane of the pelvic brim with moderate pressure on the head. An examination for the above purpose should be made every week. Palpation of the child *in utero* enables one to estimate the size and

the relation of the head to the pelvis with remarkable accuracy. The sagittal suture can be felt in some cases approximately parallel with the transverse diameter of the brim. If this diameter lies far back of the transverse and more than midway between it and the promontory of the sacrum, there is reason to suspect disproportion between the head and pelvis. The ossification of the head can be estimated by its hardness, its sutures and fontanel. The mere size of the child is not important if the pelvis is large enough. A common mistake is to take the anatomical conjugate for the obstetrical conjugate of the brim.

The author draws the following conclusions:

1. Gestation is protracted more often than is supposed.
2. When protracted gestation leads to excessive size of the child in reference to the pelvis, the conditions are essentially the same as in minor contractions of the pelvis, but more favorable for mother and child, and should be treated on the same general principle.
3. Induced labor by modern methods is safer for a normal pelvis and a fully developed child than in a contracted pelvis and for a premature child, and should not materially exceed the risk of normal labor.
4. Such a method of treatment reduces the mortality for the mother and child and requires counsel.
5. If by palpation and by Ahlfeldt's tables the child is large in proportion to the pelvis; if the sagittal suture approaches the promontory of the sacrum; if the head is well ossified; and if the largest circumference of the head will barely enter the brim by pressure from above; then labor should be induced without regard to the period of pregnancy.



## A SYMPHYSEOTOMY COMPLICATED BY PLACENTA PRÆVIA.\*

BY MAURICE WORCESTER TURNER, M. D.

**W**OMAN æt. thirty-five; native of Cape Breton; married October, 1890. (Husband's first wife died of phthisis; second of carcinoma uteri.) Shortly after marriage became pregnant. When I was engaged in succeeding winter I suggested an examination, and found a contracted pelvis. Following gives measurements normal and as found in my patient :

	LUSK	CASE
Iliac crests .....	10	11½
Anterior superior spines.....	9	10½
Brim-conjugate.....	4½	4½
Brim-transverse.....	5½	4½
Outlet-conjugate.....	3½ + 1	3½ + 1
Outlet-transverse.....	4½	3

Dr. Southwick, who saw case with me, advised terminating pregnancy at about seventh month; but before that time patient miscarried, May 29, 1891, and at about sixth month of gestation. The sub-occipito-bregmatic circumference of fetal head was 8½ inches; labor was slow, difficult, requiring perineal forceps.

Toward close of 1891 became pregnant again. About 7½ months afterward I induced labor. Head was forced into pelvis, but became impacted before reaching perineum. Instruments used. Child dead; head much compressed and elongated. Sub-occipito-bregmatic circumference being 10½ inches. Perineum lacerated, also cervix uteri. Recovery slow. This, as the writer says, occurred August 20, 1892. One month later, September 22, 1892, I was called in consultation in a case of labor, where I found the pelvis

\* Abstract of paper presented to American Institute of Homeopathy, Buffalo, 1897.

normal, but the child's head large and slow in molding; latter was firmly wedged in pelvis. Forceps applied, and after considerable effort the symphysis separated with a distinctly audible snap; the separation amounting to over  $1\frac{1}{2}$  inch. Child dead, the sub-occipito-bregmatic circumference being  $13+$  inches. Recovery uneventful, with firm reunion of pubes. This case following so shortly upon the failure in the other case in August, suggested symphyseotomy in future cases of contracted pelvis. Had advised former patient against again becoming pregnant, with the usual disregard of the counsel.

A reference to the preceding table shows that I had a funnel-shaped pelvis to deal with, one in which the brim is but slightly or not at all contracted, while the pelvic outlet is more or less diminished in all its diameters, but especially in the transverse, giving a pelvis wide above and narrow below.

[The author calls attention to some drawings which were to accompany the paper, but evidently were forgotten. They were to show the normal as well as the contracted pelvis herein spoken of; also the similarity between the male pelvis and the case in hand.]

In looking over the literature of the operation of symphyseotomy, we find the fundamental indication is the amount of pelvic contraction, which is determined by the length of the true conjugate, which, according to Morisani, should be not less than  $2\frac{5}{8}$  inches, nor greater than  $3\frac{1}{2}$  inches. Pelves larger or smaller than these calling respectively for induction of labor prior to term or Cæsarian section. Assuming that the other diameters in contracted pelvis within the limits just given are the same relative length as in the normal pelvis, it would mean a circumference at the brim of  $9\frac{1}{2}$  to 12 inches, and at the outlet of 8 to  $10\frac{3}{8}$  inches respectively. It is obvious that as the case did not have a shortened conjugate, either at the brim or outlet, a much better method of comparison is by the

circumferences of the brim and outlet, which are  $13\frac{1}{2}$  and 11 inches.

Put into tabular form we have :

	NORMAL	MORISANI'S LIMIT	CASE
Circumference of brim.....	16	$9\frac{1}{2}$ to 12	$13\frac{1}{2}$
Circumference of outlet.....	$13\frac{1}{2}$	8 to $10\frac{1}{4}$	11

Consequently the case does not fall within the bounds prescribed : it rather calls for the induction of premature labor ; but having tried this and failed to extract a living child, division of the pubic articulation seemed justified.

This pregnancy began August, 1896, III-para, April 26, 1897, being about  $7\frac{1}{2}$  months gone. Patient had previously gone to Baptist Hospital, Parker Hill Avenue, Boston, and was carefully prepared for the operation. Antiseptics not deemed necessary ; external part shaved, and vagina cleansed with sterile water and a sterile covering applied.

Monday, April 26, at 5.30 P. M. I began induction of labor. External examination showed child's head presenting, occiput anterior and to the left. Internal examination admitted index finger readily into os uteri, revealing a marginal placenta prævia, posterior and to the left, so that I inserted the bougie along the anterior uterine wall ; vagina was packed in the usual way. Progress gradual, pains slight. Vagina was emptied and cleansed twice next day. Wednesday (third day) at 11 A. M. os was large as half dollar, soft and readily distensible. Introduced fresh bougie, posterior and to the right to avoid the placenta, and then tamponed. Progress more rapid and dilatation complete at 6 P. M. At 7.30 P. M., assisted by Dr. William P. Defriez, I operated. Patient in dorsal position on table, etherized, catheterized, and external parts cleansed. Vaginal packing and bougie removed, disclosing a moderate hemorrhage from placenta. Vagina washed with sterile water ; membranes were ruptured and forceps

applied. On making traction could feel resistance increase as head descended, just as force required increases progressively when trying to pull or push anything through a passage which is constantly decreasing in size, so that the improbability of delivering a living child was manifest. A dead fetus could, of course, have been extracted. The articular notch was readily found, and with a slight incision at the upper end of the joint, division was attempted by the subcutaneous method, but failed on account of the firmness of the articulation and its extra width; wound was then enlarged, until it was a little longer than the width of the symphysis, directly over and cutting down to the joint. A probe-pointed bistoury was introduced above and behind the bone, and the articulation divided from above downward and forward. This took some time. After division separation was not favored, but prevented by lateral pressure on the pelvis. Thighs were flexed on abdomen with knees apart, and pressure applied on each side of the pelvis. In that position delivery was accomplished. Extraction was *very* easy, hardly any force being required.

The pubic bones were separated about one inch; child was asphyxiated, and only resuscitated after considerable effort, with stimulation. Placenta came away at once, the uterus contracting firmly without hemorrhage. After delivery the knees were put in apposition, the legs straightened out, and only slight pressure was required to keep the ends of the bones in apposition. The periosteum was approximated with sutures of catgut, which included the interarticular cartilage, as it was separated on both sides, and nearly free except at the left posterior margin. The deep parts were brought together with buried catgut sutures, and the skin with interrupted and stay sutures of silk. A simple dressing was applied of sterile gauze, and over it absorbent cotton fastened with collodion. Over this was a pad of gauze and a strip of surgeon's plaster,

four inches wide, was carried around the pelvis and lapped in front, and outside of all a binder was carefully fastened. There was slight shock. Union of the bone and integument was by first intention. The patient was kept flat on her back for two weeks, being occasionally rolled on her side; at the end of four weeks she left the hospital for home. She is to wear an elastic belt about the hips for some time—six months perhaps. After the operation the temperature gradually rose to 102° F. on the fourth day, but it rapidly dropped to normal, and from that time there was no fever of any account.

Baby weighed between  $4\frac{1}{2}$  and 5 pounds. The sub-occipito-bregmatic circumference was  $12\frac{1}{2}$  inches; and the head was slightly elongated. It lived for over six weeks in an incubator, and on account of there being no breast milk has been fed on artificial food. It has gained altogether  $3\frac{1}{2}$  pounds. At the present time both mother and child are doing well.

Regarding increased width of the pelvis as a result of the symphyseotomy, there is said to be usually a gain of half an inch. I find that the transverse of the brim in this case is now  $4\frac{1}{2}$  inches, which is an accession of one-fourth of an inch.

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## IMMEDIATE REPAIR OF THE CERVIX UTERI.\*

BY F. H. HONBERGER, M. D.

THAT lacerations of the cervix uteri do frequently occur during parturition is, I think, self-evident. They probably occur in the same proportions as lacerations of pelvic floor and perineum, the most frequent form being unilateral or bilateral, which are the ones most frequently calling for attention. The anatomical structure of the cervix being

\* Condensed report of a paper presented to the American Institute of Homeopathy, Buffalo, 1897.

weakest laterally may account for their more frequent rupture; while the anterior and posterior portions are thicker, containing more fibrous tissue, while the columnar arrangement of its internal coat gradually thins out as it reaches the lateral surfaces.

Why these lacerations? It is claimed that the occiput is the most frequent cause; again that it only occurs when the anterior lip is caught between the symphysis pubis and head. Improper or only partial flexion of the head and too rapid descent through the cervix may certainly be a prime cause. The use of forceps in inexperienced hands doubtlessly is responsible for many such ruptures.

To diagnose a laceration immediately following labor is not always easy, unless it be quite extensive; but after making repeated examinations it can be quite readily detected. Such examination can be more readily satisfying by having an assistant press the fundus down into the pelvis, while with a tenaculum or bullet forceps gentle traction is made upon the cervix until it is brought down into view. If a tear is detected, I bring the edges together with a pair of bullet forceps, caught in each point of the tear; interrupted sutures are then taken, beginning at the upper angle of the wound, using catgut. I have sometimes used silk-worm gut, allowing it to remain in position two weeks. Stitches must not be inserted too close to the margin and do not draw them too tight, lest they cut out. I have had perfect union in about sixty-five per cent. of cases, with my experience confined to hospital practice and to cases of instrumental deliveries with trained assistants in attendance.

It is not an operation to be recommended to the formal practitioner, except perhaps in the larger cities, as in towns and country practice trained nurses cannot always be had.

When an opportunity offers I believe we should undertake the immediate repair of cervical lacerations the same as for perineal tears. The uterus thus treated will the

more readily undergo involution and be much less liable to displacements than when left with the lips perhaps widely separated by an extensive laceration.

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### DYSMENORRHEA.\*

BY JOHN KENT SANDERS, A. M., M. D.

AS long as dysmenorrhea is discussed and treated of in text-books by teachers and by essayists as a malady rather than a symptom of diseased conditions, there is bound to be some confusion as to classification.

The following six cases are selected because they all consulted for relief from this particular symptom, dysmenorrhea, and had all been treated by other hands for the same trouble. They are cases taken at random from the work of the past year, and illustrate what is considered by the writer the most reasonable, the most simple, the most scientific, and the most plausible classification. That is, to divide the dysmenorrhea under three distinct anatomical heads of ovarian, tubal, and uterine.

The first two cases illustrate the *ovarian division*, and in former classifications would be considered "neuralgic dysmenorrhea" and "congestive dysmenorrhea" respectively. The real pathological conditions, however, were located in the ovary, and as soon as the true condition was recognized were easily amenable to treatment.

CASE I. Miss D., aged twenty-one. Good family history. Began menstruating at thirteen years of age. Three years ago she was exposed to a thorough wetting just at the first day of menstruation. There was a suppression accompanied with severe headache, backache, and pains in the ovarian region, coming with some fever. The pain lasted for ten days, but she was feverish and feeling miserable until the menstrual time again—in

\* Read before the American Institute of Homeopathy, July, 1897.

twenty-eight days. Then she had severe pain in the ovaries, which kept up for two or three days, but was relieved at the beginning of the flow. Before this suppression she had never had any pain that was noticeable. She kept up comparative good health, with the exception of dysmenorrhea, till about one year ago, when there was a decided increase in the amount of pain, limited however to two or three days preceding the appearance of the discharge, and always with quite considerable fever for a few days before and during the menstrual period. A diagnosis had been made of "neuralgic dysmenorrhea." She had had antineuralgic treatment. Several changes of climate had been advised and made on the hypothesis of a neuralgic diathesis. Each change would usually be followed by a slight improvement in the symptoms but with no permanent relief.

She came under personal observation for the first time ten months ago, when she was taking very large doses of morphine to relieve the pain of an especially aggravated attack of dysmenorrhea. During the interval between this and the next period bimanual examination was made. The uterus was about normal in size, in good position, not particularly sensitive. There was a mass in the right side of the pelvis, ovoidal in shape, three inches in longest diameter, which was very sensitive. There was also a smaller mass in the region of the left ovary, equally sensitive, but the tubes could be felt between the two masses and the uterus and were not particularly sensitive. Diagnosis was made of some degeneration of the ovaries and a laparotomy advised. This, however, was not permitted until after the second period, when the suffering was so great at those two times that there was a demand for relief on the part of the patient herself. An exploratory incision was consented to by the parents, which was done February 15, 1897. There was a little ascitic fluid in the abdomen, otherwise the peritoneum did not show any stage of inflammation. The uterus was normal, the tubes were slightly enlarged but had no inflammatory exudate around them. The right ovary was very much enlarged and boggy. The left one was less large but had the same boggy feeling. The removal of both ovaries was urged and consented to by the parents.

The patient made an uneventful recovery and is now apparently



in perfect health, taking hearty exercise every day and has had no pain since the operation.

On cross section the ovaries were found badly diseased. There was one abscess cavity nearly an inch and a half in diameter, containing thick ropy pus. There were several smaller abscess cavities scattered through the tissues, and an excessive amount of connective tissue through the entire ovary. The left ovary was in about the same condition with fewer abscesses, and the largest one only about half as large as that in the right ovary. The vaginal examinations, with a speculum, before and subsequent to the operation, never disclosed anything but a simple catarrhal endometritis.

CASE II. Mrs. D., aged thirty-four. Married at nineteen. Has five children, the youngest one three years old. Has been suffering for three years from severe pains at the time of menstruation, but never had any trouble to speak of before the birth of the last child. The labor then was normal; there were no complications. The child, however, suffered from a severe attack of ophthalmia two days after birth. The lochia after this labor was not unusually long nor was there any history of leucorrhœa subsequently. She began menstruating the third month with quite considerable discomfort; this has steadily been increasing. The pain was invariably limited to the time three days before the flow began, with then almost immediate relief. She had been subjected to a long course of treatment with vaginal tampons, and even intra-uterine applications, with a diagnosis of a "congestive dysmenorrhea" and a condition of subinvolution.

January 5, after bimanual examination under ether, a guarded diagnosis was made, as she had very thick abdominal walls and scarcely anything could be made out by this examination. A laparotomy was advised, and consented to within a week. On January 11, 1897, both tubes and ovaries were removed. The womb was found in about normal condition, and so were the tubes, but both ovaries were atrophied, cirrhotic, and unusually adherent.

The case made a fair recovery but with the formation of two stitch abscesses. These, however, did not impede the convalescence materially, and she was around on her feet the sixth

week. She has had no pain of any kind, and is in better general health than for years past.

The two following cases are neither of them uncommon, and yet neither of them would seem to go well under the old classification, and both would come under the head of *tubal dysmenorrhea*. The third one was undoubtedly caused by a mechanical defect in the line between the ovary and the uterus from the pressure on the tubes by the misplaced uterus. The fourth one it is impossible to classify in any of the old divisions.

CASE III. Miss E., aged twenty-five. Good family history. Has been accustomed since leaving college in her twentieth year to a great deal of violent exercise. She is an army officer's daughter and spends most of her time at her father's post in the West, where she is constantly on horseback and does a great deal of bicycling and lawn tennis playing and latterly golfing.

She started menstruating at fifteen without any pain to speak of, until within two years, since which time she has had a constantly increasing dysmenorrhea of high grade; very severe for two days before and relief as soon as the menstruation is thoroughly established. She had been told that she had serious ovarian troubles, and had been treated for some time on this hypothesis without any relief. Bimanual examination nine months ago showed a retroverted uterus about normal in size, not an unusually small os externum, considerable tenderness of the ovaries and through the entire pelvis. The uterus was easily placed in position and kept there for two weeks with the occasional use of a tampon. However, there was again a displacement caused by riding a wheel, and after some three months' treatment I advised an Alexander's operation, which was done. The round ligaments were found and shortened  $1\frac{3}{4}$  inch. She was kept quiet for two months, with occasional local treatment of glycerine-iodine. The past six months she has been out West again riding horseback and doing violent exercise, but with no dysmenorrhea or discomfort in the pelvic region.

CASE IV. Mrs. D., aged twenty-five; married three years. No children. History of gonorrheal infection from the husband one

year previous. Symptoms of vulvitis and vaginitis well marked. The leucorrhœa diminished gradually with astringent douches. Second menstrual period, after she was first taken with the specific trouble, was very painful, the pain coming on two days before the flow started. Dysmenorrhea was increased at each month, and at the last two periods the pain has been excruciating, with considerable fever. There has been a gradual loss of flesh and strength; excessive constipation has been uniformly present. There has been little pain between periods except that referred to the general abdomen. An examination revealed a large mass occupying the position of the left broad ligament, and a smaller mass, sausage-shaped, in the right broad ligament. Laparotomy was done December 20, 1896. The uterus was in about normal position and condition, but the broad ligament on the left side was broadened out and formed the wall of a large abscess. This was removed with a great deal of difficulty, on account of extensive adhesions of the sigmoid flexure. These were dissected off with a good deal of care, and imbedded between the folds of the intestine and broad ligament was the ovary, with all the appearance, save the peritonotic adhesions, of a normal ovary. The ovary and broad ligament and tube were removed, with a small rupture just as the mass was being taken out of the abdomen. The pus, however, fell on a packing of iodoform gauze, which was quickly removed, and no infection of the peritoneum resulted. The right side was treated in the same manner. The adhesions being less there was less difficulty and no rupture of the sac.

The patient made a protracted recovery, the wound healing quickly without any peritoneal infection, but a bad case of cystitis was started, which took some little time to get rid of. There was also a high grade of endometritis with considerable tenderness around the womb, and leucorrhœa, so much that the sixth week after the ovariectomy the uterus was dilated, curetted thoroughly, washed out with a ten per cent. solution of argonin and packed with iodoform gaze. The packing was removed the second day and repacked. This was left out the tenth day but the vaginal packing retained until the cessation of the cystitis, some three weeks later.

In the past three months the patient has been rapidly gaining

health and strength, and reports a better condition than since her marriage.

The following two cases illustrate what would be *uterine dysmenorrhea*. Case V., although having a pinhole os, which is sometimes given as a cause of so-called "obstructive dysmenorrhea," in itself would not have been a sufficient cause for the pain if it had not been for the endometritis which was clearly disclosed in dilatation. Case VI. is so obviously a result of endometritis that it is easily classified under the head of uterine.

CASE V. Miss J., aged twenty-three. Started menstruating at fourteen. Menstruated a year without difficulty. Then complained of trouble with her eyes, and some defect was discovered, which was remedied by glasses. The past two years she has been suffering severely from dysmenorrhea. The pain invariably came on after the establishment of the flow, and gradually increased for twenty-four hours, but was not entirely relieved until the cessation, about the fifth day. During these attacks her eyes gave her a great deal of trouble, she being unable to read even with different glasses that were tried, and suffering from photophobia and lachrymal irritation. Examination disclosed a pinhole os, in which with difficulty a small uterine sound was introduced. There was a small mucous plug at the os, and slight degree of erosion. Under chloroform the womb was gradually dilated with Hegar's dilators, and after a slight dilatation a few drops of pus came out of the fundus. The dilatation was continued until a medium-sized dull curette could be introduced, when the entire endometrium was thoroughly curetted and washed out with a 1-4000 bichloride solution. A slight packing of iodoform gauze was put in after thoroughly drying the tract. This was removed at the end of twenty-four hours. Subsequently for ten days a douche of solution of succus calendulæ was given daily.

It is now seven months since the operation. Menstruation has been regular and painless.

CASE VI. Mrs. T., aged twenty-eight. Been married five years. Has been a constant sufferer from dysmenorrhea since

her marriage, has never been pregnant, and has never taken any means to prevent conception. The husband excessively passionate and very desirous for children. Examination showed a high grade of endometritis, considerable eversion of the mucous membrane. A constant discharge of muco-purulent character. The pain at menstruation comes on with the establishment of the flow, is almost labor-like in its character, and lasts from three to four days, the flow coming away in firm clots the first four days and a dark ropy discharge following for three days afterward. The same general treatment was carried out in this case as in Case V., except the packing was replaced daily in the womb for ten days. She was kept in bed for three weeks, until after her first menstruation, which was painless and not clotted. Intercourse was forbidden until after the second monthly. At the third month she failed to menstruate, which was caused by pregnancy, which went on to full term, when she was delivered three months ago of nine-pound child. She started menstruating six weeks after labor, and has menstruated twice since without any pain.

The motive in the submission of this group of cases is not only to emphasize the judiciousness and practicability of the classification here chosen to define the different forms in which dysmenorrhea may be presented to us, and to advocate the necessity of prompt surgical relief in case of failure of regimen and therapeutics, but to urge the pressing need of a broader view of this malady, and a more careful discrimination as to its ætiological and pathological conditions. With a more comprehensive and accurate differentiation of these cases, and the improved management that would be the inevitable result, dysmenorrhea will soon cease to be regarded and designated as it now is "the curable yet uncured malady of women."

# OLD CICATRICES AS A RESULT OF LACERATIONS AND RUPTURES OF THE BODY AND FUNDUS UTERI, A CAUSE OF DISEASE NOT HITHERTO DESCRIBED.\*

By J. M. LEE, M. D.

FROM early recorded obstetric practice, complete rupture of the uterus has been well understood and for many years skillfully treated. Can as much be said of those old cicatrices as a result of lacerations and ruptures of the body and fundus uteri which were either incomplete or insufficient for the passage of the child into the cavity of the abdomen? The obstetricians answer, "We think not; we have seen none of these cases, neither have we read of them." This is probably true, for when the laceration does not transmit the child into the abdomen, you do not discover it; and, so far as literature is concerned, the condition, to my knowledge, has not hitherto been described. Nevertheless, we have met with three cases in connection with our hysterectomy work, in which the women were total wrecks from neurasthenia directly traceable to irritation from cicatrices of the above lacerations.

The symptomatology is not markedly dissimilar from that of laceration of the cervix, except that it is much more severe.

The diagnosis cannot often be made before the operation of hysterectomy; yet the interior of the womb may be contracted from the cicatrization of from two to four rents, which give the cavity a roughened and narrow feel as determined by the uterine sound. While in one patient the cicatrices are readily broken through by moderate use of the dilator, and even the pelvic cavity opened, in another the scar tissue may resist safe pressure on the instrument.

The indications for treatment can only be successfully met by hysterectomy.

\* Read before the American Institute of Homeopathy, June, 1897.

In one of our cases, as a result of the tears, inflammatory deposit had formed in front of the uterus, and aided us to decide in favor of the operation. We were not certain, however, in two of the cases that hysterectomy was the best plan of treatment, until the dilator was introduced and the usual pressure on the handles caused the blades to rupture through the scar tissue, so that the sound readily passed into the abdominal cavity. It is our experience that when this accident occurs, malignant disease or old cicatrices exist which demand hysterectomy. At any rate, this has happened five times in my practice, and the specimens proved that removal of the uterus was demanded, in two cases by the condition under discussion, and in three for cancer of the body and upper portion of the cervix. One of the above patients was twenty-one when married, and is now but thirty-nine years of age. During her married life she had eight confinements, all of which were normal except the sixth and eighth. These were difficult forceps deliveries, from which it took, in the former four, and in the latter eight weeks to convalesce.

It is difficult to tell just when the accident occurred, or whether the damage was all done at one labor. The fact, however, that her recoveries from the sixth and eighth accouchements were both abnormal, that forceps were used in both, and that she was slow in her convalescence would indicate that most of her injuries occurred at these confinements. Although fourteen months have elapsed since her last accouchement, her strength has not improved and she was obliged to give up all care. When she came under treatment she had a very sallow complexion, was peevish, and everything disturbed her; she was restless and slept but little; had marked pains about the uterus, expressed as chiefly in the sides, and back of the head and neck; could not think, and felt as though she would lose her mind. In short, she suffered from a genuine attack of neurasthenia.

In the other one I was unable to find sufficient cause for

her profound invalidism. Yet her symptoms were clearly referable to the pelvic organs ; and when the dilator broke through the cicatrices and opened the pelvic cavity, hysterectomy became necessary, and the uterus affords ample explanation for her profound disease.

Another case, in which we had a similar experience, had been admitted to one of our hospitaux, and treatment afforded no benefit. She somehow found her way to us, and the case seemed to be one in which the cause of her suffering was centered in the pelvic organs, yet careful examination was not adequate for the discovery of the lesion. There was relaxation of the parts, and one of the ovaries was prolapsed and sensitive. Yet these conditions did not sufficiently explain the gravity of her disease. From the examination, we felt hysterectomy scarcely justifiable. Her physician believed that the cause of her trouble was centered in the uterus, and strongly urged its removal. We finally consented to follow his advice, and there were to be found the old cicatrices in the body of the uterus, which explained the cause of her condition. She began to recover, as it seemed, from the date of the operation. She became more cheerful as time passed, and soon sat up in bed, then in a chair, and finally walked about the ward with the aid of the nurse, which she had not been able to do for years. She left the hospital at the end of the sixth week, soon began to take walks and rides in the open air, and within a year had regained her old time flesh and strength, and remains well.

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### PEDOLOGY.

THE chairman, Dr. A. A. Clokey, of Louisville, Ky., as soon as the meeting came to order, read his "Sectional Address," in part as follows :

I know of no marked advance made in the methods of



diagnosis, of treatment, or in pathology, and while the discovery of new remedies and the extended knowledge of older ones will influence the treatment and the clinical history of many of our better known diseases, there are other diseases which will never be more satisfactorily treated than at present until their pathology is better understood. Individual opinions have been advanced along these lines, but no one of them has received sufficient support to entitle it to consideration in a sectional address. It was said in the address before this association last year that "the study of the coming decade in pediatrics will be hygiene and prophylaxis." I would emphasize, if I could, the importance of preventative medicine, but I should begin it years before the child was born. It seems to me that the study of heredity offers the physician of to-day the widest field for investigation and the greatest possibilities of success in any subject, but more especially in pediatrics, for in no class of patients does heredity play so important a part as in children. The diseases which are peculiar to adult life are usually complicated by the effects of years of excesses and dissipation; the same features enter into consideration in the treatment of children, but they are the sins of the parents handed down and, as such, are far more subtle, more difficult to detect, and equally as difficult to control as when acquired by the patient himself.

The physician must study the subject in the concrete, for what applies to one disease may be wholly irrelevant to another. There are very few of our chronic diseases which are not influenced in some way or another by heredity. This influence may become very complicated, as it does in nervous diseases, for instance. How shall we explain the inheritance of migraine or epilepsy by the child of an hysterical mother? Why should one child of such a mother be the victim of migraine and another of epilepsy? I do not believe we have even begun to realize the far-reaching effect of heredity. It is to bring out the impor-

tant relation of heredity to some one disease that we have this year selected the "rheumatic diathesis" for our subject, it being one of the diseases the hereditary tendency of which it is exceedingly important to know, but is as yet little understood.

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## THE ÆTIOLOGY OF THE RHEUMATIC DIATHESIS.\*

By A. P. HANCHETT, M. D.

THERE are those who believe that rheumatism is always the result of exposure to cold or dampness and contend that there is nothing whatever in the inflammatory process which is peculiar to the disease, save in the location. This is probably the oldest theory that is held by any at the present day, and finds its chief support in the fact that the disease often occurs after such exposures. But such exposures are so common, if this theory be correct, the wonder is that any escape attacks, or that it is not epidemic at certain inclement seasons of the year, and much more prevalent in cold countries, while scarcely seen in mild or tropical regions. It is, however, a disease of the temperate rather than the arctic regions, and is more common in moderate than in severely cold weather. We also observe in acute rheumatism that one joint after another becomes affected without the least possible exposure, the patient being in doors, often in bed, while this continued extension is going on.

Again advocates of the lactic acid theory tell us that inflammatory rheumatism is due to an acid condition of the fluids of the body, and they fortify their statement by demonstrating the acidity of the saliva, of the perspiration, and the increased acidity of the urine. The presence of lactic acid in the blood and other fluids of the body is,

\* Abstract of a paper presented to the Section in Pedology, Am. Inst. of Hom., Buffalo, 1897.

by these writers, considered the cause of the swollen and painful condition they find existing in the joints and muscles, whereas those opposing this theory consider it a consequence of the inflammation set up by other causes. The exceedingly acid condition is admitted, but is accounted for by its production in larger quantities by the tissue changes going on in rheumatic subjects, and its retarded elimination from the body when a patient is suffering from this disorder. They consider this acidity as only one of the attendant conditions of rheumatism, as are also the profuse sweat, the swollen and tender joint, and the severe pain.

Let us consider the contagious and the miasmatic. The inflammatory processes resulting from a contagious poison are communicable from the sick to the healthy; and they have definite periods of duration, while one attack generally affords immunity from the disease. But rheumatism is never communicated from the sick to the healthy; it has no established period of duration, and a repetition of the attacks is rather the rule than the exception. It cannot, then, be due to a contagious poison, but, rather, miasmatic bearing more relation to malarial troubles; and when we note that rheumatism, like malaria, is more prevalent in low, damp sections, moist climates, and at seasons of the year favoring the development of miasmatic poisons, that certain people are more liable to attack than others, that it is non-contagious, and has no regular period of duration, we must decide that it is closely related to malaria, and should be classed with it as of miasmatic origin. This rheumatic, or miasmatic poison, is found to effect only certain organs and textures in which the muscular and serous or other fibrous tissues predominate, and which seem to have no other feature in common, as the joints, the muscles, and the heart. With the joints it is not the bones but the fibrous and serous tissues which are involved, as the tendons, ligaments, and the synovial membrane; and

also, with the heart, the fibrous structures of the rings and the valves and the serous membrane covering and lining it are more likely to suffer than is the muscular substance.

All organs provided with fibrous and serous textures are not equally affected, and some rarely. The small joints of the toes and the articulations of the ribs are but rarely attacked, and yet here we find ligaments and fibrous and serous tissues. The same class of tissues are found investing the brain and spinal cord, covering all the bones, covering and giving support to all the abdominal, thoracic, and pelvic viscera, far exceeding in extent the tissues of this kind existing in the large joints and the heart so much more subject to the attacks of the rheumatic poison. We look for an explanation of this difference in susceptibility of similar textures, and find that it is almost wholly those parts engaged in controlling and regulating movement that become involved in rheumatism; so that rheumatism is a disease of the motor apparatus, with its chief seat in the fibrous and serous structures.

Many diseases seem to run in families; that is to say, they may be transmitted from parent to child for generations. Rheumatic parents need not be surprised when their children develop some of the manifestations of rheumatism. When we say the child has inherited rheumatism we do not mean that he was born with the disease, either in an active or latent form. The child may be free from the disease at birth, and for years, until indeed some favorable moment arrives, when rheumatism will result because of this susceptibility. The child may be born before the parent has himself developed the disease which he is believed to have transmitted, or it may not show itself in one generation at all because of insufficient exposure to the specific rheumatic poison at a susceptible time. Thus, as we understand it, it is not the disease itself but a peculiar predisposition and susceptibility to it which is transmitted. For the production of rheumatism, then, two

known factors must be brought together, the miasmatic poison and the favorable condition of those tissues on which it acts. Now, which of these factors has our patient inherited? It cannot be both, or we should have the conditions for fully developed rheumatism at birth; and, moreover, it cannot be the former, for the miasmatic poison is something which, from its very nature, must be produced outside the body. It must, then, be the second, or that condition of the tissues of the motor apparatus that renders them favorable to the development of rheumatism by the propagation of the rheumatic poison. We are wholly unable to determine to-day what that condition is. No known test can be made of the fibrous or muscular tissues of several children that will determine which have this peculiar susceptibility to this poison and which have not. Neither the pathologist, the chemist, nor the microscopist can find a trace of it, yet as soon as the one is exposed to it this subtle agent finds lodgment, propagation, and growth, while in the other it will not. In the one there is clearly something different in the tissues of the motor apparatus than exists in the other, and it is this difference which constitutes the rheumatic diathesis. If it is inherited, it is this susceptibility which is inherited, and if acquired, it is this which is acquired.



## THE PATHOLOGY OF RHEUMATISM.\*

BY W. H. BIGLER, M. D.

[T will be necessary to premise, first, that in spite of marked differences between the clinical manifestations of rheumatism in children and in adults, we regard the pathology as the same. Second, that no theory of the pathology of this disease can be regarded as absolutely perfect at the present time, in the sense of being able adequately to explain all its varied manifestations. Third, that no theory can be accepted as even approximately correct, which fails to take into consideration and offer some explanation of the existence of an hereditary predisposition to this disease. Holt has said that in fully two-thirds of the cases a rheumatic history was obtained.

There are at the present time three prevailing theories on this subject, the neurotic, the lactic acid, and the miasmatic theory. The first, if it can be found capable of accounting for all the phenomena, seems to be the most consistent with the prevailing doctrine of physiology—that the controlling influence in every physiological act, and in the performance of every normal function, resides in the nervous centers. What more natural and logical than to seek to trace the same influence in pathological processes, which are really but diverted or perverted physiological ones? The existence of transmissible peculiarities of nerve structure, not yet discoverable by chemical or microscopical means, is recognized as more than a mere hypothesis in the general neuropathic constitution, the result for instance of alcoholism or of epilepsy, and the cause of so many and such varied diseases of the nervous and muscular and glandular systems. It has been demonstrated that such conditions, when not inherited, may be acquired by

\* Abstract of a paper presented to the Section in Pedology of the American Institute of Homeopathy at Buffalo, 1897.

excessive activity of the nervous system, and by prolonged excesses. In this perhaps lies the explanation of the cause of the hereditary predisposition to rheumatism under this theory.

Dr. MacLagan is an eminent exponent of the miasmatic theory, and in an article on rheumatism in the "Twentieth Century of Practice," in seeking to establish his peculiar views, has subjected both the neurotic and miasmatic theories to a sharp and rigorous test, which he divides into seven divisions, wherein he says that the especial characteristics of rheumatic inflammations are, first, the tendency to its occurrence is hereditary; second, it is especially liable to occur at a particular age; third, it is apt to attack the same individual more than once; fourth, it does not confine itself to one joint; fifth, it attacks also the membranes of the heart; sixth, it very rarely terminates in suppuration; and, seventh, it is not much benefited by measures calculated to relieve simple local inflammatory action, but is speedily subdued by proper constitutional treatment.

This same author, already quoted, asks, if cold, for instance, be the most common cause of the peripheral nerve irritation, which sets the malady a-going, why is the disease more common in temperate than in cold climates? Why is it most common between the ages of fifteen and fifty? Why so rare among children and older people, whose power of resistance to colds is so much less. And how shall we explain the invasion of new joints after the patient has been warm in bed for days? How shall we account for the appearance of endocarditis and pericarditis? Why is the endocarditis so limited in extent? Why does it affect only the valves on the left side, and only one surface of the valve? How shall we account for the presence of lactic acid in the system?

We will now address ourselves to these questions: Exposure to cold or damp is regarded as the exciting

cause of a rheumatic attack, and even by the others it is conceded that the disease most frequently follows upon such exposure. It is important to observe that an exposure to quickly varying temperature, or an unequal exposure of parts of the body to the same temperature, is more frequently followed by rheumatic fever, than when the whole body is exposed at the same time to a change of temperature. In determining these questions the author referred to the "American Text-Book of Physiology, 1896." The heat mechanism consists of two fundamental parts, one concerned in heat production and the other in heat dissipation. Nearly every tissue of the body may be regarded as a heat-producing structure by virtue of the oxidation processes which lie at the base of all forms of vital activity, but the skeletal muscles and the glands are exceptionally active as heat producers. The contractions of the heart also produce an appreciable amount of heat, while considerable heat is formed directly by the resistance offered by the blood vessel walls to the blood current, so that from five to ten per cent. of the total heat production is furnished by the heart. . . The mechanism which affects the blood supply to the skin, the quantity of sweat secreted, the condition of the skin, the quantity of air inspired, all these must, in a large measure, regulate thermolysis. . .

We will now proceed to some facts in regard to the nervous system, more particularly with reference to reflex activities, which will be of use to us in the treatment of our subject. It is proved that a physiological, if not an anatomical, continuity obtains between all parts of the spinal cord which are concerned in reflex action; that the nervous network intervening between the afferent and efferent fibers forms along the whole length of the cord a functionally continuous field; that this network is, so to speak, mapped out into nervous mechanisms by the establishment of lines of greater or less resistance, so that the disturbances in it, generated by certain afferent impulses, are directed into



certain efferent channels. Still the arrangement of these mechanisms is not a constant one. We can always predict exactly the nature of the movement which will result from the stimulation of any particular spot, because the result will vary according to the condition of the spinal cord; while under a change of circumstances a movement quite different from the normal one may make its appearance.

After further explanations and quotations touching this interesting point, Dr. Bigler says :

1. The predisposition to rheumatism, hereditary or acquired, consists in an abnormal state of unstable equilibrium in the thermogenic mechanism, the result in the individual, or in his ancestors, of too frequent or too prolonged stimulation in the temperature to which they have been exposed. The essential factor in its production is the variation, not the actual temperature; continued cold or continued warmth tends to "set," so to speak, the mechanism for the established norm; so that the equilibrium is preserved, whereas sudden changes and variability tend to unsettle, and, if frequently repeated, to destroy the co-ordination which normally exists between its several parts. Hence rheumatism and the rheumatic disposition are found most frequently in temperate climates, where the variations in temperatures are most marked.

2. Nature's reactions are always, in the first instance, directed to a definite purpose, which is normally reached, but by reason of abnormal conditions of the nervous apparatus, they may become excessive or deficient or misdirected according to the portion of the reflex arc at fault. In the attempt to ward off the effects of cold, applied from without, the efforts are directed through the motor nerves, which, as we have seen, preside over the katabolic processes, which give rise to muscular contraction, with its accompanying heat-production. Hence the motor apparatus and the heat-producing tissues are affected probably in the order of their relative stages of development and functional

activity. . . Hence, in children predisposed to rheumatism, it is apt to show itself in the motor apparatus—chorea. The reason for rheumatism selecting the left heart, and particularly its fibrous structures and valves, is their greater functional activity.

3. The reaction to external impressions is always salutary. Hence, exposure of any kind, if not too long continued, will not be followed by symptoms of rheumatism in those not predisposed, whereas in presence of the same cause, in the case of those whose thermogenic mechanism is in a state of unstable equilibrium, the action will become excessive, and the effects will first show themselves in the prodromal symptoms which characterize the onset of acute rheumatism. The application of cold in this condition does not act by stimulating this condition, but it primarily stimulates the heat-producing center, and removes artificially enough of the superfluous heat to allow a balance between the two centers to be restored, temporarily at least.

4. The occurrence of rheumatism in early life is much more frequent than was formerly supposed, and is owing to the imperfectly developed condition of the nervous system, especially in regard to the reflex connections. Two cases of infants attacked by fever and swelling of joints, the one twelve hours after birth, and the other at the end of eight days, both born of mothers at the time suffering with acute rheumatism, are quoted from Jacoud as showing the infectious nature of rheumatism.

5. If we bear in mind what has been said as to the tissues included in the thermotaxic mechanism, and the lines of greater and less resistance, for the passage of efferent impulses, it will explain the various so-called complications of rheumatism more readily and more logically than any other.

6. The comparison between the phenomena of malarial fever and those of rheumatism, and between the action of quinine in the one, and of the salicyl compounds in the

other, as drawn by MacLagan, although very interesting and ingenious, are not sufficiently convincing to prove the miasmatic origin of rheumatism, especially in view of the fact that both of these remedies often fail of their effects in their respective diseases, although given *lege artis*, in the large doses said to be necessary. A glance into our homeopathic literature will further tend to destroy the illusion that we are justified in reasoning back from the supposed specific action of the salicyl compounds to the equally supposititious pathology of rheumatism. Besides this nothing corresponding to the *plasmodium malariae* has been discovered in the blood of rheumatics, and the most ardent hunters of microbes have failed to run down any which are characteristic of this disease. The original lactic acid theory, among other defects pointed out by MacLagan, fails to explain the cause of the excess of lactic acid, and hence we are thrown back upon a neurotic theory of rheumatism.

7. The theory as here developed differs from the neurotic theories hitherto advanced in that it points to a disturbance of a specific part of the nervous system, in which, on the basis of universally acknowledged physiological facts, all the various phenomena of rheumatism and its complications find a simple and logical explanation.—ED.

#### *Discussion.*

DR. JOS. P. COBB.—In the light of our recent investigations the theories under discussion are not generally wholly understood. I shall refer to the neurotic portion of the paper in particular. There are certain peculiar symptoms usually present. There is a rise of temperature which comes at a certain time. This rise of temperature is in proportion to the severity of the case or the condition of the patient. As regards this temperature, the nerve theory fails to my mind on this point. It does not say what has thrown the system, and especially the temperature point, out of balance.

Rheumatism has its most marked appearance in the fibrous

tissues, in the serous tissues, and other active tissues. It picks out those fibrous tissues which are in most constant use. In the serous tissues also, those parts which are most active are the parts involved. In the synovial tissues also, we find this fact marked. The pleura and the pericardium are rarely involved—and there is usually an amount of serum present in those conditions. This serum contains a small number of leucocytes and other different forms of micro-organisms, which we find upon analysis. Primarily it is the fibrous tissue which is involved. When it is muscular, it is the fibrous tissue which is affected, and this prevents the muscle from contracting. As a matter of fact the endocardial serous tissue is not primarily involved, and it is the fibrous parts of the valves, and the fibrous structures only, which are involved. An inflammation is caused by the presence of much friction.

Endocarditis on the other hand is a disease produced by the presence of micro-organisms, and is hence a disease produced by infection. Endocarditis is the most frequent condition in children of rheumatic tendencies. In these cases it is the endocardium which is almost invariably either partly or wholly involved.

Let me direct your attention for a moment to chorea. Recent authors claim that in one-third of all the histories of chorea the history of rheumatism can be established in the family. In other words, the choreic diathesis can be traced in fully two-thirds of all the cases of rheumatism which occur in childhood. And again I want to call attention to a paralysis which seems to exist in some of these cases. In the last year-book it is stated that all conditions of rheumatism seem to depend upon infection. Is there not still inherited from tuberculosis a tendency which can produce the infection? If you will look at rheumatism closely you will find the same to be true. We all recognize that the majority of the cases of rheumatism in children, and all rheumatic inheritances, can be obtained and transmitted in several generations of a family. This appears to be all that is necessary for any condition of rheumatism. This predisposition is the condition which renders one liable. I don't mean to state that no one will have rheumatism without the inheritance of it. The inheritance is an important factor, but it is not the whole factor, it is only one

of them. Chorea is a disturbance of the nervous apparatus governing a muscle. We have just as much right to say that chorea is a disease of the muscles. It seems to me that it is a disturbance of the nerve centers—a disease of certain definite nerve centers, and manifested invariably in the same manner if coming from the same nerve center.

The relationship which chorea bears to choleo-myelitis, the relation which chorea has to rheumatism, the relation which it has with endocarditis as regards the similarity of the tissues involved, and the commonly accepted theory that endocarditis is a microbic disease, lead me to place the disease in this group.

DR. N. B. DELAMATER.—I do not quite accept the microbic aspect of rheumatism, at least not in its present condition. There are, however, some points which bear upon that condition. All three of the diseases mentioned seem to be frequently the result of the same kind of reflex irritation, all three seem to be the result of the same kind of an environment, and all three are invariably found in persons of which there is some one or other kind of hereditary history. So far as my experience is concerned with myelitis and other diseases of the nervous system, I have never seen a case in which there has not been the same general characteristics. There is present that kind of destruction, or rather disturbance of nutrition, which will produce cell change, but not change in the right direction, but such as will bring about cell destruction. This produces a diseased condition of the system. This cell is of course the primary tissue element, or its individual member, and in this cell is performed the function of nutrition. The power to take nourishment from the circulation resides in these individual cells. Whenever a cell is underfed, its function is altered ; when anything will interfere with its function, then we have a condition and a tendency to a something—whether it is a microbic agency or not, I don't know ; I believe it is not.

## TREATMENT OF THE RHEUMATIC DIATHESIS.

BY S. R. GEISER, M. D.

**I**N the treatment of this disorder, stress may be laid upon the fact that the most successful physicians do not treat the disease so much as the patient. The manifestations of a rheumatic diathesis are not the same in every system, and cannot all be treated in the same manner, nor by the same remedies, some people disclosing a susceptibility toward the encroachment of disease not found in others. The intensity of the disease may also be modified from peculiarities of the tissue structure, or other causes; there are certain powers implanted within us that enter into the composition of the most infinitesimal structures of our systems, and like sentinels point out to what extremes we may go. Constitutional taints of disease may oftentimes be eradicated by the recognition of sanitation, the preservative powers of healthy environment, proper diet, bathing, etc. Thus the physician will point out how health may be conserved, and also be performing the specialism of his art, and not of his learning.

There is a medicinal and a hygienic treatment. The use of drugs, other than tonics and digestives, are by far subordinate to the hygienic treatment. In a majority of these cases there is always more or less anæmia, where the supply of proper and sufficient nutrition is the first indication to be met. Disease could never rise unless some alteration occur, either in the matter of supply in the form of nutrition or from the metabolic activity of each particular cell.

It follows therefore as a necessity that the bringing of the part or parts into normal condition again can be done only first and foremost by proper nutrition and, second, by proper medication.

\* Abstract of a paper presented to the Section of Pedology, Am. Inst. of Hom., Buffalo, 1897.

As to diet, experience has proven that rheumatic children do much better upon a diet composed largely of nitrogenous food, where the starches are restricted in amount. Milk should be given in all cases as the principal food.

If the uric acid theory is correct, the body should be cleared of the offending material, for which the alkaline treatment would be indicated; the results, however, have not always been satisfactory. Solvents of this acid, viz., benzoic and salicylic acid, have always been found beneficial. To rid the system of uric acid a proper diet, above all, is necessary.

Where a uric acid diathesis is manifested in nursed babies, it is due to too high a percentage of proteids, which may be reduced by causing the mother to take more exercise. Infarcts in the kidney and small calculi in the urethra, due to the excess of uric acid, are often the cause of much crying and suffering in infants. Here the hot bath relieves.

A pregnant woman of rheumatic diathesis should, during this time and while nursing, abstain from meats, broths, eggs, beer, and wine, which are said to decrease the alkalinity of the blood and favor the precipitation of uric acid. It is possible by avoiding all animal foods which contain xanthin compounds, and also tea and coffee, whose alkaloids are similar xanthin compounds, to limit very materially the introduction of uric acid into the body, then after it has been eliminated, to keep the excretion of uric acid in the urine below the relation of urea of one to thirty. Proper diet then ranks first and drugs second in importance in the management of the rheumatic diathesis. The use of alkalies, especially in large doses, is not of so much value as generally supposed, and, when used at all, should be used only in the robust and in those cases where there is hyperacidity of the urine. This would not be homeo-therapeutics, but chemico-therapeutics. The good to be derived from the waters of mineral springs lies not alone in the

alkali which they contain, but in the large amount of water which is drank in order to get the alkali. This may also be said of the various lithia waters and of many waters which are on the market. Washing out the tissues by causing the patient—whether during pregnancy or in case of a child—to drink large quantities of water, is beneficial within certain limits.

The underclothing should be of flannel during the entire year, in summer the slightest weight being worn; carefully protect the feet from exposure, particularly from dampness. It is needless to say that the spring or winter, or better still, the entire life of the child, should be spent in some warm, dry climate. In order to restore the general tone and to increase the standard of the red blood corpuscles, and to increase the resisting power of the tissues to the disease, ferric phosphoricum, arsenic, nux vomica, or strychnine will be of service. In pale, anæmic, sensitive subjects lycopodium and cuprum will be of no less value, the former especially if the urine contains lithic acid deposit. Where there is a history of rheumatism, or muscular pains with manifestations of chorea of the mother during pregnancy, or chorea in the child associated with myalgia, or rheumatic ailments, cimicifuga will be indicated. In cases where the characteristic urinary symptoms are present, berberis will be of incalculable value in eradicating the tendency to rheumatic diathesis. Where dampness seems to be the exciting cause, dulc., rhus tox., and natrum carb. will be called for.





## THE URINE IN RHEUMATISM.\*

BY CHAS. E. KAHLKE, M. D.

Dr. Kahlke having been appointed at the eleventh hour, so to speak, to fill the place of another to whom this paper had been originally assigned, apologized for the incompleteness and other evidences of haste which might be apparent, and then said:

Although this subdivision of the general topic—rheumatism—is one of the most important, we find in general but a very limited amount of literature in regard to it. It is important because the condition of the urine is an absolute index of what is going on in the blood, and it is upon the latter that lithæmia, rheumatism, and gout depend for their manifestations. Therefore, he said, we look to the urine for our diagnosis, this being the disease factor upon which our treatment must ever depend.

So far as therapeutics is concerned, we very well know that what controls the flow of water from the kidneys controls also exhalation from the lungs as well as controlling the digestion and all its secretions.

The urine, as we all know, in the case of rheumatism, is usually high-colored, highly acid, depositing on cooling a brick-dust sediment containing amorphous urates and, only occasionally, crystals of uric acid. The perspiration being plentiful and the quantity of urine diminished, it is natural to expect a high specific gravity, 1.025—1.035. The chlorides may be entirely absent, or at least greatly diminished. We may find a transient or febrile albuminuria in cachectic cases, due to a slight catarrh of the tubuli uriniferi. We also find peptomuria, a rare form of albumin, in acute rheumatism; but, as it is sometimes found in so many different conditions, it is of no value in diagnosis. Phosphaturia is present in chronic cases. When the temperature drops and convalescence is established, the urine

\* Abstract of a paper in the Section of Pedology, presented to the Am. Inst. of Hom., Buffalo, 1897.

assumes its normal quantity and appearance. The examination, from a bacteriological point of view, is useless.

It is uric acid and its relation to urea that we would emphasize as the most important point in this urinalysis, for we believe it to be the cause of the manifestations of the malady in question. As the reaction of the urine indicates the reaction of the blood, and as it is upon the latter that the uric acid depends for its solubility, and hence excretion, we shall first consider the acidity of the urine.

The urine in rheumatic individuals is habitually acid, in consequence of an excessive presence of acid phosphate of sodium. This acidity is very marked in all acute attacks, and is in inverse proportion to the uric acid. Fluctuations in the acidity of the urine corresponds both in direction and in extent with the fluctuations in the alkalinity of the blood. A highly acid urine means low alkalinity of the blood. Hence, in this condition, we would expect the uric acid to be diminished in the urine, and be driven from the blood into the joints, etc., as it depends upon the alkalinity of the blood for its solubility. Of course, when a very large amount of uric acid is excreted, we are liable to have a markedly acid urine, the acidity being due largely to the uric acid itself. The acidity is increased by the suppression of perspiration, and, naturally, diminished by increased perspiration; hence, in old rheumatics, we find that hot rooms and warm southwest winds diminish the acidity of the urine and increase the excretion of uric acid, this giving rise to the feeling of languor and depression which is due to the uric acid in the blood. Cold northeast winds would bring about the opposite condition. The acidity of the urine bears a fairly constant relation to urea, both tending to rise and fall together, and the relation—1 of acidity (reckoned as oxalic acid) to 6.1 of urea—is very constant. This is probably due to their being the results of one and the same metabolism.

Now, as regards uric acid and urea, it is not so much the

absolute amount of each excreted in the 24 hours (little less than 12 grains of the former and 384 grains of the latter) that concerns us, as their relative excretions. Normally the relation of uric acid to urea in the urine is 1 of uric acid to 35 of urea. But when we have a condition of rheumatism we find a relative diminution of uric acid and increase of urea, because the excretion of uric acid is in inverse proportion to the acidity. High uric acid is dependent upon two factors, (1) the low acidity of the urine, corresponding to high alkalinity of the blood, and rendering that fluid a good solvent for uric acid, and (2) the presence somewhere in the body of a quantity of uric acid available for solution when the condition of the blood becomes favorable for solution. As for the various tests by which the above points are determined, I shall simply refer you to the text-books.

DR. ST. CLAIR SMITH: We can speculate upon the theories, but they bring us down to one fact, and only one fact, that we can grasp, and that is—children, subject to frequent attacks of tonsillitis, are pathologically similar to those who develop tubercular disease, in that they inherit these tendencies and constitutions from their parents, and are hence predisposed to one of these infections in particular—perhaps to all. With rheumatic diathesis it is the same, although the fact has not been proven or demonstrated by either the pathologist or chemist, and we can only acknowledge that these conditions exist when we see the patient. I have no doubt that rheumatism, as it occurs in children, is of microbic origin. The condition present in endocarditis proves this. It has been proven that this is bacterial. As to pathological changes, if there is one thing positive in this disease, it is that there are no decided changes. When changes occur, we are to deal with another condition—not rheumatism, but probably some other form of endocarditis, and which may require surgical intervention. Let us illustrate: A child has stiffness in the neck; it cries when you take it up; it shifts about in its bed; it is somewhat ænemic, and there is a little fever; later on perhaps it develops increased stiffness of the neck; there is more and higher fever, and

all the bad symptoms are increased. A surgeon is now called, and in the examination the spine presents painful areas; afterward the physician, perhaps, becomes aware of the fact that the child has not been sleeping well of late. Examination of the heart determines a distinct blowing in the mitral orifice. This is a case of rheumatism in a child. These conditions are micro-organic. The lesion in this case is the same as in any other microbic disease. Chorea frequently follows rheumatism in children. In my opinion, it fastens itself upon children that are neurotic; children that always feel an attack of subacute rheumatism—it is very rarely more than that. We frequently see it follow cases of diphtheria or typhoid fever. I have never seen a case of typhoid fever in a child which was not followed by either chorea or rheumatism. Chorea is the cause of rheumatism in children more often than any other disease.

DR. C. B. KENYON : We have rheumatism in strong children, we have it in the strongest, we also have rheumatism in the strongest constitutions in the adult, simply caused by exposure, and there may not be a particle of tendency in these cases. I recall a family that I had under treatment in which there was no apparent cause, nor was there any condition of tendency evidenced, but in which I found a very severe case of rheumatism. I have no doubt that the case was of microbic origin.

DR. J. L. HANCHETT : We all know that yellow fever has its periods, it has its bounds, it has its time and place. So I believe it is with rheumatism. There are some cases of rheumatism which occur at certain periods, certain months of the year, and in certain years only. That is, they—the patients—are not affected during all times, but only when certain conditions are present. The farther we go south the more rheumatism we find. This would prove, for one thing, that the germ of rheumatism has its habitat in warm climates. I think this to be a germ disease, and that it is hereditary, and that the tendency can be transmitted.

DR. A. H. LAIDLAW : Is it allowable to say that rheumatism is a microbic disease? We do not know that it is. We may find out later, but we don't know what it is at the present time. We have no right to say that it is, unless we know, and are absolutely certain. Any poison entering into the circulatory system may set up

conditions in various parts of the body; it is not always localized in a certain part, and we should keep that in mind probably more than these theories until they have been settled.

DR. CHAS. E. KAHLKE : I assume rheumatism to be simply a condition of the blood in which the latter is saturated by the chemical substance, uric acid. This condition of the blood is brought about by the indiscriminate use of meat diets. We have here a condition of uric-acid-omia. While there are so many notions and ideas as to the cause of the condition the uric acid idea seems to be the most plausible to me. Others admit that uric acid can produce the symptoms found in rheumatism, and that the uric acid condition is brought about by meat dieting, and also that this condition brings about an alkalinity of the circulation. The symptoms depend upon the amount of perspiration. This can be brought about by any high temperature, consequently a chill, which produces a rapid rise of temperature in the circulation, will bring on this condition, and so a case of rheumatism can be developed. It is a well-known fact that at the time of menstruation in women the temperature is increased, and the rheumatic conditions are manifested in the fibrous tissues of the uterus. People with corns or any fibrous growth have a good barometer, because these tissues during certain kinds and conditions of the weather are affected, when at other times they are not noticed. In regard to the heart : where there has once been a weakening disease or a condition wherein the heart was in some way affected, we have a fertile place for rheumatism to take hold and make rapid progress.

DR. J. H. CARMICHAEL : During twenty-six years of practice I have met a great many cases of inflammatory rheumatism. The first thing I prescribe is the remedy which is indicated, and then the total abstinence from meat diet. I don't allow my patients to take any meat until I am through with them, and know that it will not harm them. I give the homeopathic remedy I find indicated. In 1873, at a meeting of physicians, we heard much about salicine, and we gave salicine thereafter, but from a year's experience we found that the remedy would not do its work. A relapse usually followed what we thought to have been a cure. Finally I began an investigation to determine why salicine would

not cure, since it seemed to attack the disease somewhat. I found that it needed an adjuvant, and someone suggested merc. sol. From this and salicine I got good results.

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## THE BEFORE AND AFTER TREATMENT OF ABDOMINAL OPERATIONS.\*

BY HOMER I. OSTROM, M. D.

**A**SIDE from the technique of an operation, and the necessary manipulative skill that goes to make up the mechanically perfect surgical procedure, the condition in which the patient is at the time of the operation will have much to do with her ability to resist shock, and to overcome any functional disturbance that may have been caused by the violence done the system. For when we consider an operation, it presents these two aspects mainly: the mechanical aspect, and the particular, or general, disturbance of function.

No part of the body can be treated with violence, a necessary result of any operation, without the whole organism being called upon to repair the damage so done, and it goes without saying that the success with which this is accomplished will depend largely upon the condition of health, or otherwise, that the organs are in at the time the demand is made upon them. If the balance between repair and waste is not properly maintained, the individual organ, as well as the general system, must suffer, and hence there is no reserved strength to meet the sudden demand, a demand for resistance and recuperation, for the organism is already taxed to preserve health.

Having these general principles in view, my object in preparing patients for an abdominal operation is to place as

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nearly as possible each organ, especially those of elimination, in a condition of perfect functional activity. To this end, I have my patients in my Private Hospital forty-eight hours before an operation. During that time the kidneys are thoroughly examined, and this includes a chemical, as well as a microscopical, examination of the urine. The excretion of solids by the kidneys I regard as of the utmost importance, for many cases of stormy convalescence after laparotomy are, I believe, due to uræmic poisoning. The specific gravity, therefore, and the proportion of urea, receive especial attention before an operation.

Touching the treatment of the kidneys, I direct that the patient shall be given as much water as she can drink. Any pure water will answer the purpose, but I prefer Poland Water; it is a pure water, and has a slightly diuretic action. The free use of water has a dual action; it not only stimulates the kidneys, but it supplies the system with water, and, I have thought, relieves the thirst that is so trying a feature of the first twenty-four hours following an abdominal operation. One very decided effect of the free use of water before an operation is the marked activity of the kidneys immediately after the operation. Formerly it was usual to have the secretion reduced to four or five ounces in the first twenty-four hours following an operation, but with the free use of water, the quantity is soon almost normal. The almost entire absence of nausea after my abdominal operations may, I think, be partly due to this eliminating action of the kidneys. The nausea and general gastric disturbance very closely resemble uric-acid poisoning, and I have certainly had less of this since I flushed the kidneys than before.

Next I turn my attention to the liver. This gland is also one of the great eliminating glands in the system, but it is more, it is a chemical laboratory, in which septic organisms are destroyed, and passed on into the system as innocuous bodies. The importance, therefore, of preserv-

ing the health and activity of the liver needs no demonstration. Should any septic condition arise, the bile, if properly secreted, and in sufficient quantities, will dispose of these organisms and assist in averting septic intoxication.

I therefore am in the habit of giving merc. dulc. until the liver is thoroughly active; generally two or three powders will accomplish this. I always follow the merc. dulc. with a Seidlitz powder.

Usually this will be sufficient to clear the intestinal canal, but if not, I give pulvo glisco. the night before the operation, followed by a good enema the morning of the operation.

The diet receives my careful attention. For twenty-four hours before the operation the patient gets nothing but nitrogenous food, thus leaving as little as possible in the stomach and intestines. The patient, then, comes to the operation with her food digested, and no residue in the intestinal canal. Under these conditions even ether nausea is rare.

Of course it goes without saying that the heart and lungs are carefully examined.

So much for the treatment before the operation. The after treatment I consider no less important. In the first place the patient receives immediately after the operation, and while she is still thoroughly relaxed from the anæsthetic, and in the Trendelenburg position, an enema of two liters of normal salt solution. This is thrown well up in the colon with a long tube, and, if done during complete anæsthesia, will be retained. The action of this is twofold: First, it relieves, or rather diminishes the risk of shock, by favoring the absorption of fluid into the abdominal circulation, and thus preventing the accumulation of blood in the abdominal vessels, and the consequent anæmia of the heart and brain. Second, it assists the action of the kidneys and supplies the system with water, thus assisting in relieving the intense thirst that follows opening the



abdominal cavity, and the administration of an anæsthetic. Where formerly I ordered a nutritive enema, I now find better results to follow the normal salt enema. It is questionable whether, in the condition of the system immediately following a severe operation, the absorbing powers of the intestine are sufficiently active to take up any food or nourishing material. And it is still more questionable whether, if the nutritive enema is taken up, it is utilized. More likely it remains undigested and acts rather as an irritant. On the other hand, the salt solution is very readily absorbed by the intestinal lymphatics, and passes directly into the circulation.

My former rule was to withhold all water from the patient for the first twenty-four hours. I believe this to be too strict, and now give my nurses directions to begin the use of hot water the night of the operation, if there is no nausea. Usually, by the following morning, they get two ounces every two hours, but they have no food until the expiration of forty-eight hours, when they begin to get two ounces of hot milk alternated with the hot water every two hours. From this, the patients by easy stages, through farinaceous food and broths, gradually reach a light convalescent diet by the end of the first week.

On the third or fourth day, if all goes well and no occasion has arisen to move the bowels before, the patient is made more comfortable, and convalescence is more rapid, by inducing a free evacuation of the bowels. My favorite method for this is to give a dose of Epsom salts; if there is any reason to believe the liver is not acting, *merc. dulc.*, or, better still, a tablet of calomel and soda, followed by the salts, or a Seidlitz powder, will clear up the case, and it will pass on to recovery without any other medication. Indeed it is not unusual for me to carry through a laparotomy, with no other medication than that which I have indicated, to complete convalescence. My rule is to give no more medicine than is necessary, and always to be guided in the

selection of the remedy, and the course of treatment, not only by the symptoms, but by the physiological requirements as well. If we disregard these, we are working in the dark, and our efforts will be ineffectual in restoring health, for, inasmuch as we have attacked Nature with violence, we should not depend wholly upon her recuperative powers to restore the disturbed equilibrium, but should assist her efforts by bringing to our aid some mechanical means toward health.

A consideration of the use or non-use of morphine, after an abdominal operation, naturally falls within the after treatment of these cases.

Let me preface my remarks upon this subject by saying that I am opposed to the general use of narcotics in the treatment of disease. But let me at the same time qualify this remark by explaining that I refer to the indiscriminate use of this class of remedies. Let us use, not abuse the forces that are placed in our hands. Let us learn when to give, and when to withhold, that wonderful class of medicinal agents that possesses the power to relieve suffering and cause sleep.

I regard morphine as the type of this class of drugs, and I look upon its intelligent use in surgery as a dial upon which is written the index of the true physician, as well as the successful operator. I cannot but feel that those who assert that morphine is never indicated, and has no place in abdominal surgery, are either not familiar with its use, are wanting in experience, or are governed by prejudice.

The indications for the use of morphine in abdominal surgery are quite as clearly defined as are those for any other remedy; and while every case does not require morphine, in my practice those that do require the drug have it administered to them.

Let us look a little at Nature's side of a laparotomy, and consider what we have done to the system generally, and what we have a right to expect will be the natural results of our manipulation.

In the first place we have opened, and treated with more or less violence, the largest serous cavity in the body, one containing many organs essential to life. There naturally follows shock to the entire nervous system, and disturbance of innervation. To resist this shock, the whole nervous system is called upon, and quickly passes into what I may call a condition of clonic irritation, a state entirely opposed to the rest necessary to repair.

In this condition we have the indication for the use of morphine. The system needs rest. The nervous waste has been great and must be repaired. Therefore, let us quiet the system, and give nature an opportunity to repair the damage we have done. Morphine will do this, and I know of nothing else that will. No dynamic remedy can act while the system is in the condition in which we find it after a severe operation, and in order to place the system so that it can be acted upon, we must give it rest, during which time all function is held in abeyance, waste is arrested, and Nature assisted in her efforts at self-restoration.

To produce this effect with morphine, it is not necessary to administer it in large doses. It is not necessary to bring the patient completely under its influence, but it is quite sufficient to induce relief from pain, relief from the nervous apprehension that almost always follows in a greater or less degree a severe operation, and a relaxation of the nervous system. No degree of self-control on the part of the patient after an operation, can enable her to remain quiet in the face of physical pain, or worse, nervous exhaustion, and the restlessness that comes with it. This restlessness is in itself a source of danger to the patient, for, by yielding to it, local damage may be done, and much needed strength wasted.

Acting upon this belief, that rest is essential to recovery from the shock that must follow any severe operation, my patients, if they are restless, suffer much pain, or have a sub-

normal temperature and rapid heart's action, receive, even immediately after the operation, and before they have recovered from the anæsthetic, a hypodermic of one-fourth of a grain of morphine. This will usually quiet them, and always shortens the period of shock. I find it not unusual, after administering morphine, for the temperature to rise to normal, and the pulse to become slower and stronger.

The first twenty-four hours after an operation is the quiescent period. Nothing develops, unless as the immediate effect of the operation. Nature is resting, and our position is limited to watching, ready to assist if necessary. This is the time for morphine, for then it is an adjunct to Nature's efforts at repair. Later, I am entirely opposed to its use. It then covers and masks everything. At the time when reaction is asserting itself, when the objective and subjective symptoms indicate what is going on, we must not cover these up, but must use them as valuable indications for treatment.

After the first day, my patients rarely have any morphine, for then, as I have said, it hides from us most valuable information, and also produces its peculiar effect upon the intestinal canal.

I have thus dwelt rather at length upon the use of morphine in abdominal surgery, for the reason that so much prejudice exists among surgeons against its use—prejudice which I cannot but think is unreasonable, and withholds from our patients one of the instruments which we possess for their good. Many cases recover without the use of morphine, and many do not require it, but when they do require it, I think we are remiss in our duty, and do not give our patients the benefits of science, if we refuse to give them this most valuable and useful drug.

I do not urge my patients to rise early, and especially when the case has been an uneventful one. These are the ones that should be the most carefully watched, for the patient, feeling well, sees no reason for remaining quiet, or

for the caution that is insisted upon. Certain processes must be gone through in the reparative work of Nature, and these consume time. Tissues cannot be strong, new parts cannot be firm, in less time than Nature has fixed. We, therefore, in directing our laparotomy cases, so far as the getting up is concerned, should have regard to the physiology of repair, and not permit them to walk or exert themselves before the third week, no matter what the condition is. I am confident that, if this rule is observed, there will be fewer cases of relapse, and a greater number of permanent cures, than we now have. Cases will not come back to us for local treatment, and with the complaint that the old pain is no better. It is far wiser to lengthen the period of convalescence, and make the cure a permanent one.



SOME OF THE PECULIARITIES OF THE ANATOMICAL  
STRUCTURE OF CHILDREN.

BY W. H. BIGLER, M. D.

WERE pediatrics to be restricted to the study of those diseases only which are peculiar to infancy and childhood, its sphere would be exceedingly narrow; but, since its object is to treat all abnormal conditions as they occur in the young, its study overlaps in many directions the field of general practice.

All diseases in children, whether peculiar to them or not, show more or less variation from the adult type, the result of two intimately connected factors, the functional and the anatomical. The change in environment to which the infant is compelled to adapt itself at birth, causes a rapidity of functional activity in some directions in striking contrast to the slower and more difficult adaptation in the adult. It is natural to suppose that the occurrence of disease during this endeavor of nature to bring the new being into harmonious relations with its surroundings, should be attended by symptoms both more intensive and extensive than where such relation has already been established. Hence the wide range of reflex actions in the child must always be carefully considered. The anatomical structure of the infant, suited for its existence *in utero*, is compelled to take on certain modifications under the influence of the changed conditions and developing functions. These original variations and gradual changes will cause changes also in the symptoms of disease. Although we may presume that the subjective symptoms are not exactly the same as in the adult, they can be but imperfectly studied in the child, and therefore are of minor importance as compared with the objective signs, as a means of localizing lesions and diagnosing diseased conditions. It is the purpose of the present short paper to point out some of the

more important peculiarities in the anatomy of the child, in as far as they have a bearing upon the manifestation of disease, and our means of its recognition by physical examination.

We will pass them in review without observing any order but a typographical anatomical one.

Beginning at the head, therefore, we notice that in the ear the osseous meatus is not developed until about the fourth year; hence, if there be occasion to introduce a speculum before that age, the external ear must be drawn forward and downward, and not upward and backward, as in the case of adults. We must remember, too, that at birth the membrana tympani is nearly horizontal, and only gradually assumes its adult inclination. The eustachian tubes are also horizontal at birth, and while at first the opening is very small, during infancy it becomes absolutely larger at its narrowest part than in the adult; a fact which affords a ready explanation of the ease with which catarrhal processes travel from the naso-pharynx to the middle ear.

The respiratory portion of the nasal cavity is very narrow and the naso-pharynx very small. The dangers of what might seem trifling catarrhal conditions become apparent when it is considered how a little congestion and secretion may cause complete obstruction, with its accompanying disastrous effects upon the neighboring parts, and remotely upon nutrition and growth.

The shape of the thorax in infancy and childhood differs from that in the adult. The antero-posterior and transverse diameters are about equal in the newborn, but after the third year the transverse diameter is always the greater, although it is not until puberty that the chest assumes the shape as found in the adult. The lungs are, therefore, situated rather more posteriorly than in the adult. The ribs form the sides of the thorax, and the cartilages and sternum the front, and, owing to the cartilaginous condition of these structures, the thoracic walls are very elastic and

yielding. The top of the sternum is higher than in the adult, reckoning from the spine, and its lower part relatively poorly developed. The ribs are also more horizontal than later. These circumstances serve to explain the great irregularity in the type of respiration. The rhythm of respiration is easily disturbed, and in young infants a regular rhythm can only be found during sleep. The lungs do not expand equally, and at certain times and in certain positions respiration may be carried on almost entirely by one lung. Hence, circumstances and conditions which, in the adult, would be of necessity impossible or fatal, may be met by the infant with impunity. The length of the interval between inspiration and expiration varies much at different times, and regular rhythmical respiration is not established before the end of the second year, so that even marked irregularity may have little or no significance.

The lungs do not reach their full expansion until the fifth or sixth year, or later. In the beginning the bronchi are larger, more numerous, and occupy a greater space; the air cells are much smaller and occupy less space. Their epithelial cells are very numerous, with a tendency to rapid proliferation (Northrup). The interstitial tissue is much more abundant than in the adult lung (Delafield). These peculiarities must constantly be borne in mind in studying diseases of the respiratory organs in infancy and childhood. On account of the small size of the air cells, acute congestion may interfere with their function almost as seriously as complete consolidation. The tendency of inflammation to spread from the larger to the smaller bronchi is very much greater than in the adult, while the rapidity of respiration in all forms of pulmonary diseases is also much increased. Owing to the large size of the liver, there is a marked difference between the percussion of the right and of the left lung. On the right side, behind, the eleventh rib marks the lower border of the lung, while it descends as low as the twelfth on the left. In front, the



lung extends to about the fourth or fifth rib on the right, and to the sixth on the left.

The heart of the infant is less covered by the lungs than in adult life, and during the first year its long axis is more nearly horizontal, so that the apex beat is higher and farther to the left. According to the observations of Wesselewski and Stark, the apex beat, until the fourth year, lies outside the mammary line. If less than one-third inch beyond, it is not to be considered abnormal. From the fourth to the ninth year it is found in or near the mammary line, and after the ninth year always within the same. During the first year it is usually in the fourth interspace; after the seventh usually, and after the thirteenth always, when normal, in the fifth. Rachitis, Pott's disease, and lateral curvature of the spine, by the attendant deformities, may cause considerable variations in these figures, while on the other hand cardiac disease occurring in the young, especially up to the third year, may result in deformities of the thorax which in their turn may interfere with the normal development of the pulmonary tissue. The areas of relative and of absolute dullness vary with the age and period of development. The outline of the area of relative dullness, especially in small children, is relatively larger than in the adult, and this may lead to the mistaken opinion that the heart is enlarged, when it may be of normal size. The area of absolute dullness, the part of the heart uncovered by the lungs, resembles in shape the same in the adult, but is also proportionately larger. According to Hochsinger the accentuation is upon the first sound, and not upon the second as in adults, and on account of the previously mentioned peculiarities of the thoracic walls, all sounds, normal and pathological, appear louder and more diffused than in the adult. Reduplication of the heart sounds is not uncommon in children, and may be due simply to excitement. During the first four years of childhood nearly all abnormal murmurs heard are systolic (Holt).

The liver is relatively very large in infancy and childhood, and occupies much of the space in the right side of the abdomen which comes later to be occupied by other organs. Its edge can be recognized from three-eighths to six-eighths of an inch below the border of the lower rib in the hypochondriac and epigastric regions. It gradually diminishes in size, so that at puberty it does not extend below the rib, and but a little projects below the ensiform cartilage of the sternum in front, while in the back the lungs have reached their adult position.

The stomach at birth is remarkably small, with the fundus but imperfectly developed, and hence it is more tubular in shape and more vertically placed. Its capacity at that time is about one ounce. It develops rapidly, and the adult shape is soon acquired. Fleischmann, Holt, and Rotch have made numerous important studies of the capacity of stomachs at different ages, with special reference to the question of feeding. They have shown that it is capable of being caused to contract by too small quantities of food, and, what is of more frequent occurrence, of being greatly dilated by the opposite, and that in estimating its capacity at any period, the weight of the child, irrespective of its actual age, must always be taken into account. In the first year but little of the stomach can be reached by percussion, but in the following years, owing to its rapid enlargement, it soon comes to assume the position to be occupied in adult life.

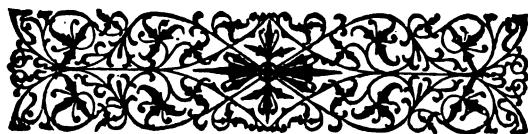
As to the large intestines, Treves has found that the sigmoid flexure constitutes nearly one-half their length at birth, but at about the fourth month it has acquired its proper permanent proportions.

The cæcum is usually situated higher than in the adult, and the ascending colon is consequently shorter. The position of the vermiform appendix is variable, but as a rule is on the posterior side of the cæcum. The fact that the intestines are less fixed than in adult life, is a strong

predisposing cause of the frequent cases of intussusception during the middle of the first year.

The kidneys are lobulated at birth, and continue so for a long time. During the first period of life, owing to the size of the liver, the left kidney lies decidedly higher than the right, but from then on they gradually assume the structure and location of the adult kidneys. An important point in regard to the bladder is, that at birth it is small, but soon becomes capable of great distention, and in infants is practically an abdominal organ, taking up nearly the whole of the lower portion of the cavity of the abdomen. It is difficult, if not impossible, therefore, to correctly examine the abdomen of an infant unless we are sure that the bladder is empty. These by no means exhaust the list of the peculiarities of anatomical structure in infant and children, but let them suffice.

In the preparation of this paper I have drawn largely from the latest authorities on pediatrics, and present it only as illustrative of the importance of the whole subject, and not as laying claim to originality or completeness of treatment of any part of it.



## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

**THE HOMEOPATHIC THERAPEUTICS OF DIARRHEA, DYSENTERY, CHOLERA, CHOLERA MORBUS, CHOLERA INFANTUM, AND ALL OTHER LOOSE EVACUATIONS OF THE BOWELS.** By JAMES B. BELL, M. D. Fourth Edition. Philadelphia: Boericke & Tafel, 1897. Cloth, \$1.50.

This little book, little in size only, not in importance, comes to us as an old friend in a new dress, having renewed the juvenescence of its youth and gone back to the convenient size of the earlier editions. It is not necessary to commend this book to homeopathic physicians, for not to know "Bell on Diarrhea" is to admit but scant acquaintance with the best of homeopathic literature, and this book, known wherever homeopathy has made its way, has been an invaluable aid in the treatment of diarrheal diseases and become a classic work. To say of a book that it is as good as "Bell on Diarrhea" is to accord it praise indeed. The present edition has been thoroughly and completely revised, but revision has revealed but few changes to make and no remedies to add or omit, so that it is now as complete as it can well be made, for at least some time to come. What was true in homeopathy yesterday is true to-day and will be to-morrow and for all time, and although fads may come and fads may go, the great principles of homeopathy are unchanged.

**A TREATISE ON OBSTETRICS.** For Students and Practitioners. By EDWARD P. DAVIS, A. M., M. D., Professor of Obstetrics and Diseases of Infancy in the Philadelphia Polyclinic; Clinical Professor of Obstetrics in Jefferson Medical College of Philadelphia; Visiting Obstetrician to the Philadelphia Hospital, etc., etc. Illustrated with 217 engravings, and 30 plates in colors and monochrome. Lea Brothers & Co., Philadelphia and New York, 1896.

This volume, of convenient size for handling, sets forth in concise words the science and art of obstetrics in accordance with

the most modern results of investigation and experience. The theory and practice of obstetrics have changed so greatly within the past few years that the text-books of a year or more ago are obsolete and the text-book of to-day will be a back number to-morrow; nevertheless this work of Professor Davis will have more than an ephemeral value. While advocating proper anti-septic precautions in attendance upon labor the author does not go to the extent, in this direction, of some modern authors, who seem to regard a normal labor as a dangerous pathological process. Upon the disputed point of abdominal palpation *versus* vaginal examination Professor Davis favors palpation. The style of the author is easy and clear, and as he believes that the nomenclature and diagnosis of the subject have been rendered unnecessarily confused by complicated terminology and theoretical distinctions, he has avoided this by a simple, direct, and practical method. The extensive experience of the author has enabled him to condense the result of recent research and put it into practical shape for the benefit of both students and physicians. Obstetric surgery, which has advanced so rapidly of late, has received full attention, and the directions for the different operations are clear and complete. The illustrations, particularly those in color, are remarkably good and deserve commendation; in fact, the book, taken altogether, is one of the best which have appeared in recent years upon this subject.

A SYSTEM OF GYNECOLOGY. By many Writers. Edited by THOMAS CLIFFORD ALBUTT, M. A., M. D., LL. D., etc., etc., and W. S. PLAYFAIR, M. D., LL. D., Professor of Obstetric Medicine in King's College, and Obstetric Physician to King's College Hospital. New York: The Macmillan Company, 1896. Cloth, pp. 950, \$6.00.

This volume, although forming a part of Allbutt's system of medicine, is nevertheless complete in itself as a treatise upon gynecology from the pens of the most distinguished gynecologist of the allopathic school in England, and it is needless to add that anything written by such practitioners as Balls-Headley, Milne Murray, W. S. Playfair, Bland Sutton, and the others will be read and well worth the reading. The opening article, The Development of Modern Gynecology, by Dr. M. Handfield-Jones, is a

fair and comprehensive review of the subject, in the course of which the writer expresses his sense of the obligation which he believes medicine owes to Sir Joseph Lister for his development of antiseptic surgery. He thinks that more of the success attained in gynecological surgery at the present day is due to antiseptic precautions than to improved methods. Dr. Berry Hart contributes the article upon the Anatomy of the Female Pelvic Organs, and Dr. Ballantyne that upon Malformation of the Genital Organs in Women. Inflammation of the Genital Organs in Women is well and carefully treated by Dr. Barbour; the article is complete, and the pathology of the affections accurately described. One of the most interesting chapters of the book is that contributed by the editor, Dr. Playfair: the Nervous System in Relation to Gynecology. The writer lays particular stress upon the lack of proper exercise and training with young girls, particularly schoolgirls. He indorses the Weir-Mitchell treatment—rest—and believes that, properly and judiciously carried out in well-selected cases, its results are most striking and satisfactory. Sterility is the subject of Dr. Gervis's article, and Dr. Routh contributes that upon Gynecological Therapeutics, which contains but little concerning the treatment of diseased conditions with remedies. Iron, permanganate of potash, arsenic, and quinine are the most important weapons in his armamentarium, although the inevitable ergot is not forgotten. Hydrastis, cannabis, and viburnum receive scant mention. Dr. Milne Murray contributes a good practical article upon the Electrical Diseases of Women, giving the indications for its therapeutic application. Among the other articles which should receive particular mention are: Dr. Halliday's Disorders of Menstruation, Professor Simpson's Displacement of the Uterus, Dr. Sutton's Extra-uterine Pregnancy. Taken in its entirety, the book is a valuable publication and contains much information in a reasonably small space.

**THE INTERNATIONAL MEDICAL ANNUAL AND PRACTITIONER'S INDEX.** A Work of Reference for Medical Practitioners, English and American. 8vo., pp. 724. Fifteenth year, 1897. New York and Chicago: E. B. Treat. Price \$2.75.

If we say that the volume for the present year is as good and valuable as those that have preceded it we have said all that

is necessary, for it is well known that the "International Medical Annual" is the best of its kind. It is complete, not voluminous, and contains a comprehensive summary of the important contributions to medical literature during the year.

The contributors, forty-one in number, are men of international reputations, and among them are found some of the ablest clinicians in the world. This task of compiling matter that would be of value is a laborious one, but the work has been well done and they have given to the profession a book that is a veritable storehouse of information, but which at the same time is not so bulky as to impair its value for ready reference.

FLINT'S MEDICAL AND SURGICAL DIRECTORY OF THE UNITED STATES AND CANADA. Issued annually; 1897. New York: J. B. Flint & Co., 1897.

The value of a list of this kind lies, of course, in its relative accuracy and completeness; absolute accuracy and completeness being impossible when changes are continually taking place at the rate of more than fifty per day. In these respects Flint's Directory is as perfect as possible; the latest changes up to the time of going to press being made, and the entire work is kept standing in type so that all changes and errors are corrected at once. Those who have occasion to use a work of this kind will find Flint's Directory the most satisfactory ever issued.

THE TREATMENT OF FIBROID TUMORS OF THE UTERUS, MEDICAL, ELECTRICAL, SURGICAL. By FRANKLIN H. MARTIN, M. D., Professor of Gynecology Post-graduate Medical School of Chicago; Surgeon Woman's Hospital of Chicago, etc., etc. Chicago: The W. T. Kerner Co., 1897. Cloth; 175 pp.; \$1.00.

This work is a series of lectures delivered at the Gynecological Post-graduate Medical School of Chicago upon fibroid tumors of the uterus and their treatment, and gives the results of the author's wide experience in the treatment of these growths. The author places more reliance upon surgical than upon medical or electrical methods of treatment, although he says, "I am constrained by sense of justice, knowing well both sides, to say in the interest of those who have fibroids of the uterus, that the knife, even in these times of brilliant successes in

surgery, is used too often and electricity too little." The benefit derived from electricity in the treatment of fibroid tumors of the uterus is still a disputed question, but the author holds to the opinion that electricity seldom fails to relieve these cases, and while it frequently fails to cure, never kills and never does harm, and never interferes with the success of an operation, if in the end it fails to cure. The book gives a complete résumé of the subject as it stands to-day with the allopathic school.

In preparation and announced for early publication, by W. B. Saunders, Philadelphia, Pa.:

AN AMERICAN TEXT-BOOK OF GENITO-URINARY AND SKIN DISEASES. Edited by L. BOLTON BANGS, M. D.

AN AMERICAN TEXT-BOOK OF DISEASES OF THE EYE, EAR, NOSE, AND THROAT. Edited by G. E. DE SCHWEINITZ, M. D.

SURGICAL DIAGNOSIS AND TREATMENT. By J. W. McDONALD, M. D.

THE THEORY AND PRACTICE OF MEDICINE. By JAMES M. ANDERS, M. D.

TUBERCULOSIS OF THE GENITO-URINARY APPARATUS, MALE AND FEMALE. By NICHOLAS SENN, M. D.

A TEXT-BOOK OF GYNECOLOGY. By CHARLES B. PENROSE, M. D.

A TEXT-BOOK OF OBSTETRICS. By BARTON COOK HIRST, M. D.

A MANUAL OF ORTHOPEDIC SURGERY. By JAMES E. MOORE, M. D.

A TEXT-BOOK OF EMBRYOLOGY. By JOHN C. HEISLER, M. D.

PATHOLOGICAL TECHNIQUE. By FRANK B. MALLORY, A. M., M. D.

DISEASES OF WOMEN. By J. B. SUTTON, F. R. C. S., and A. F. GILES, M. D.



## Materia Medica.

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***Phytolacca in Mammary Abscess.***—Dr. W. C. Richardson. —“Gathered breasts,” with large, fistulous, gaping and angry ulcers, discharging a watery, fetid pus. In ordinary caked breasts it is specific.

***Summer Diarrhea.***—Dr. Gaston. —Ferrum has painless, watery, undigested stools, at night, or while eating and drinking. Emaciation and debility, with good appetite. The least emotion or exertion produces a flushed face:

***Secale in Post-partum Hemorrhage.***—Secale is best adapted to thin, scrawny women. The hemorrhage is passive; there is a tingling in the upper and lower extremities. Although the surface of the body is cold, the patient insists on being uncovered.

***Chamomilla in Constipation of Children,*** especially in cases where soothing syrup has been used to considerable extent, in peevish and fretful children who cannot be pacified except by being carried. They have had pains with the movements of the bowels and are afraid to have a movement.

***Arsenicum in Leucorrhœa.***—Dr. McElwee.—Thick, scanty yellow discharges, acrid and burns like fire, and drops from her when standing up and when emitting flatus. It may come in place of the menses, especially in women who are easily fatigued, with waxy complexion, and who are of a chilly nature.

***Actea Racemosa in Backache.***—Violent ache in the small of the back; bearing down pains dart from the uterus to the sides; weight in the uterus; pressure, as if something were passing out; leucorrhœa profuse. Mentally she is despondent, and thinks she is going crazy. This remedy is similar to caulophyllum in uterine troubles.

***Thyroidin upon the Female Sexual System.***—The menorrhagia which obtains in myxœdema has led to the influence of the thyroid on the female sexual system being studied; it is found to have a restraining effect upon uterine, an exciting one upon mammary activity. Its extract has been used with much

success in several forms of uterine hemorrhage, and in deficient lactation.

**Uranium Nitrate in Albumin of Pregnancy.**—Dr. G. M. Christine (Hahn).—Not used as often as its symptoms warrant. It is a good diabetic remedy, and the nearer the symptoms of the patient approach those of diabetes, the more clearly is the remedy indicated. In those cases where acute parenchymatous nephritis is associated with diabetes, uranium nitrate will give brilliant results.

**Mercurius viv. in Abortion.**—Dr. L. L. Danforth.—Threatened abortion; frequent attacks of pain in the small of back; pressing pulsation in the abdomen; pressure toward external genitals, which are so swollen that the sitting posture became difficult; pressure at times accompanied by discharge of reddish menses from genitals. Repeated miscarriages at end of third month, or before. Expels moles.

**Thuja in Ovarian Pain.**—Dr. A. R. McMichael.—Pain in left ovary extending through the left iliac region into the groin and sometimes into the left leg, burning pain in left ovary. Worse from walking, riding, and during menses.

Concomitants: Menses too early and profuse. Excessively tired all the time; movements in abdomen as if something alive. Nails brittle or soft.

**Thuja in Coccygodynia.**—Dr. C. S. Elliott, Med. Aren.—Painful drawing in the sacrum and coccyx and in the thigh when sitting; a burning on the coccyx; pain as if beaten in the small of the back, extending to the tip of the coccyx; after having been seated a while, the drawing hinders standing erect; sudden cramplike pain in the lumbar region after long standing, and when attempting to walk it seems as if she would fall. Thuja has the occipital headache like that in coccygeal reflex headache.

**Senecio in Chlorosis.**—Dr. Foss, A. h. Z.—A chlorotic girl, aged eighteen, had seen no menses for fifteen months. She had a dry, teasing cough, the pulse quick, every excitement made it beat 100 and more in the minute. At the same time headache, slept badly, constipation; the abdomen during the last year had gradually increased in size. After a six-months' treatment

without benefit, a colleague in consultation recommended tapping. The abdomen was now so distended that it resembled that of a woman at the end of pregnancy. Senecio was given in the 1st dec. dilution. Improvement now set in in all directions. There was a great flow of urine, the menses reappeared, and she got quite well.

**Action of Platinum on the Uterus.**—Dr. Cowperthwaite, Med. Era.—Platinum affects the uterus only through its depressing effect upon the nerve centers, but such results are so uniform and characteristic, almost invariable, that they become the chief feature of the drug's action. While its use is largely confined to those cases where uterine and ovarian irritation has given rise to the characteristic and well-known mental states of platinum as present in melancholia, hysteria, nymphomania, pruritus, vaginismus, etc., yet the fact should not be overlooked that platinum is a most valuable remedy in induration of the uterus, fibroid tumors, and prolapsus. As a rule the platinum patient has not only the characteristic mental symptoms, but also a menorrhagia of dark, clotted blood, and an abnormal sexual appetite, while probably the most important and ever present characteristic is a painful sensitiveness of the parts.

**Pulsatilla in the Diseases of Women.**—Dr. W. A. Dewey.—When women begin to complain pulsatilla is one of the first remedies thought of. Its essentially feminine disposition of gentleness, timidity, mildness, docility, is most characteristic of the drug; even tearfulness, another feminine attribute, strongly points to pulsatilla. Then, too, we have fickleness, indecision, and changeableness, which are certainly characteristic of pulsatilla and of some women.

On the female organs pulsatilla exerts a decided action; first, let us note its effect on menstruation. It has a scanty menstrual flow, with severe griping pains which are very severe at times, so severe that the patient can hardly bear the pain; it doubles her up. Thus, pulsatilla becomes a useful remedy in dysmenorrhea. Dark menses, which are delayed and accompanied with this severe menstrual colic and the characteristic temperament, will be the indications.

The menses of pulsatilla, besides being scanty, are quite apt to appear too late.

This scantiness of the menses as well as the delay in their appearance suggest at once the use of *pulsatilla* in aménorrhœa, and it is a very useful remedy, but it must be closely indicated. Where the menses flow by fits and starts, and when due to wetting of the feet, it is indicated, as also in delayed first menses in chlorotic girls.

The leucorrhœa of *pulsatilla* is chlorotic in nature and is apt to accompany the delayed and scanty menstruation ; it is usually thick, creamy, or milky, but it may be thin and acrid and associated with the swelling of the vulva. A general distinction between *pulsatilla* and *sepia* is that *pulsatilla* is worse during menstruation and *sepia* before menstruation.

***Hydrastis and Arsenicum in Mammary Cancer.***—Lŉn. Hom. Rev.—Miss R., in September, 1891, had the right breast removed for a cancerous growth. About eighteen months after the growth returned to the cicatrix. Immediate removal by a second operation was advised by a leading Bristol surgeon, who told the patient candidly that without this second operation six months at most would end her life. Dreading further surgical treatment Miss R. was induced to try the so-called “Mattei” remedies. She accordingly placed herself under a practitioner in London who advocated such treatment, and persevered with it for a long time, but without relief until she finally relinquished “Matteism” and sought relief in homeopathy.

She was greatly emaciated, mere skin and bones, prostration was extreme ; scarcely able to move in bed. The growth in the cicatrix was about the size of a hen’s egg and gave her severe pain ; in its immediate vicinity in the healthy skin were several hard masses, each about the size of a pea. Pulse 130, small and weak. As the patient did not appear to have long to live, Dr. Morgan saw her in consultation. His opinion of her condition was most unfavorable. It was decided to try arsen. 3x, night and morning, with hydrast. 2x twice daily.

In a few weeks these remedies had effected so great an improvement that the pain in breast had gone, her spirits were brighter, pulse had come down to 80, she was gaining flesh and felt stronger. The same medicines have been continued and improvement has been steadily maintained until, at the present

time, twelve months after commencing treatment, the growth is greatly reduced in size, and the small nodules around it have quite disappeared. There is no pain, appetite is healthy, patient gets up and dresses herself daily and knits and reads. During the last three months she has been at the seaside, getting daily outdoor exercise, and seems, in short, a new woman. All this has been effected apparently by the sole use of the two remedies.

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## Gynecological Etchings.

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**Use of the Uterine Stem.**—Dr. Pichevin, Bull. et Mémoires de la Société Obstét. et Gynéc. de Paris, holds that Lefour and other contemporary authorities have rehabilitated the stem. The ill effects, once so often seen, were due to ignorance of gynecology, carelessness, and absence of antiseptic precautions. The stem is necessary in cases of contraction of the uterus after cauterization, as is so often seen when Dumontpallier's method has been used. It is also allowable in stenosis in neglected cases of amputation of the cervix. The stem is specially useful in cases of amenorrhœa and sterility, where the os internum is tender and contracted, and the body of the uterus sharply anteflexed. But it should never be used for similar symptoms when the canal is normal, or when there is pelvic cellulitis or perimetritis as well as metritis.

**Galvano-Caustic Treatment in Gynecology.**—Dr. Fredericq, Belgique Méd., is of opinion that it is truly useful only in cases of uterine fibro-miomata, and possibly also in instances of uterine atony, and that in all other affections of the genital organs it is either harmful or so inferior to other modes of treatment that it is useless to try it. Thus it is distinctly contra-indicated in sarcomatous and other malignant tumors of the ovary, and in all gynecological troubles associated with chronic enteritis and marked hysteria. It is of no value in uterine displacements, ovarian prolapse, and inflammation of the uterine appendages, while in endometritis it is inferior to curettage. In uterine fibro-miomata, however, it is

admirable as a means of stopping hemorrhage and relieving pain, and sometimes its employment makes surgical intervention possible when it was not so previously.

***Curettage for Hemorrhagic Metritis in the Virgin.***—Dr. Blanc (Loire Méd.)—Until recently purely medicinal and often inefficacious means have been used in the treatment of virginal metritis. He reports three cases in which curettage was employed for this affection with complete success, and a fourth in which permission for operation was refused by the patient's parents, and death followed. In the first two cases, aged sixteen and fifteen years respectively, the curette brought away large masses of whitish fungosities, of a firmer consistence than is usually met with in the scrapings of hemorrhagic metritis in married women; the uterus was afterward packed with iodoform gauze. In the third patient, a girl of fourteen years, the hemorrhage began at the third menstrual epoch, and was continuous; in this instance the curette removed grayish-white fungosities, of a softer consistence than in the foregoing cases.

***Fatal Poisoning by Arsenic in the Vagina.***—Dr. Haberda (Centralb. f. Gynäk.)—Maid-servant from Styria, aged twenty-five, was seized with vomiting and faintness on September 20, left her situation in Vienna on September 22, and was picked up prostrate a day later and sent into a hospital. She was almost pulseless, and the abdomen was very tender; she pretended that she was menstruating, and no pelvic examination was made, but as she stated that she was constipated an enema was given, and a stool with bloody mucus came away. There was scarcely any pulse, and she died on September 25. At the necropsy acute fatty degeneration and hemorrhages in solid viscera were detected, and phosphorus poisoning suspected, so Haberda made a closer examination of the subject on order from the magistrates. He found icterus and hemorrhages under the skin and in the muscles. The spleen was greatly enlarged, and there was recent fibrinous pelvic peritonitis. Arsenic poisoning was suspected; on searching the vagina a paper bag was found containing still a quantity of white arsenic in fine crystals. Acute inflammation of the vagina with false membrane on the labia minora and incipient sloughing of the rectal mucosa over the recto-vaginal septum were detected.

The labia majora were very œdematous. The case was probably suicidal, as the deceased had told the hospital authorities that she was menstruating so as to throw them off their guard, though the pain must have been intense and desire for relief urgent. Haberdas states that in the last century a peasant murdered three of his wives by introducing arsenic into the vagina after connection. Another wife murder was effected in the same way in 1799. In 1864 a single woman, finding herself pregnant, attempted to produce abortion by this means, but killed herself thereby. In 1890 a prostitute was murdered by a man who by force introduced a quantity of arsenic into the vagina, wrapped up in a knot of horsehair.

***Pregnancy and Fibroid Disease.***—Dr. Fernand Monod, Bull. de la Soc. Anatomique de Paris, in the course of the description of a large myoma, states that the patient was thirty-nine, and had married when sixteen years old. She had never had the least sign of menorrhagia or of pregnancy, till she was surprised by the complete cessation of the period for four months, and the development of great abdominal swelling. A bilobed tumor filled the abdomen. The left lobe rose above the umbilicus and distended the flank; it felt like a fibroid. The right rose as high as the umbilicus, and fluctuated clearly. There was also a large fibroid mass in Douglas' pouch. He removed the entire mass by complete abdominal hysterectomy. The uterus, as is not rare under the circumstances, was distended by hydrops amnii. The late occurrence of pregnancy is much more unusual.

***Vinegar as a Hemostatic.***—Dr. Estep—When there is an abortion, and the placenta is loosening and coming away piece at a time, which process sometimes requires days to complete, I use intra-uterine injections of vinegar by means of a fountain syringe and uterine irrigator. If there is no immediate danger I attempt to clear the uterine cavity by dilating the os and using a curette, but where there is threatened syncope and a general anæmic condition this procedure might prove fatal, and in such cases I use my injection and place a tight tampon. In all cases I have returned inside of twenty-four hours and found my patient quiet, free from pain, with a good pulse, etc., and on removing the tampon found the fragments outside of the cervix and no hemorrhage except a small black clot.

Cessation of the pains is an indication for removing the tampon. Afterward I use injections of hot water only. In post-partum hemorrhages I do not use a tampon, but will repeat the injection if necessary.

; *Ascites from a Gynecological Point of View.*—The characteristic symptoms of ascites are the following : Special configuration of the abdomen, curvature of the line limiting the dullness of sound with the concavity turned upward, fluctuation, variability of the dullness according to the patient's position, dilatation of the chest, projection of the umbilicus, separation of the rectus abdominis muscles, etc.

If the ascites is due to compression of the inferior vena cava there is œdema of the abdominal parietes and genital organs, pointing to an affection of the respiratory or circulatory organs.

If, on the other hand, the ascites is the result of compression of the portal vein, the œdema mentioned above does not exist ; but around the umbilicus is found a circle of dilated veins, known as the "head of Medusa." When these conditions exist they indicate an affection of the liver, kidneys, or peritoneum.

Generally it is supposed that, in a case of tuberculosis or carcinoma, the extravasation is sanguinolent ; but that is only true in a small number of cases. Ordinarily the extravasation in tuberculosis or carcinoma of the peritoneum is of a serious nature.

Fibrinous peritonitis, which is a far more frequent affection than is generally admitted, gives also rise to ascites.

Is it possible to confound ascites with other morbid processes ? There is no doubt of that. Andree thought he had to do with ascites extravasation in a case where the stomach was dilated to such an extent that it bulged out in the vagina. For my own part, I have made a similar mistake in examining a woman at the point of death, whose stomach was so much dilated that, by changing the patient's position, the same modifications were produced in the percussion sounds as are characteristic of an ascitic effusion.

There are also cases of intestinal distension which may be taken for ascites, an error committed by Frerichs.

Still more frequently there may be confusion between ascites



and unilocular ovarian cysts. I recall having seen, in 1876, a woman who presented all the symptoms of ascites, although there was no perceptible cause for this disease. Schroeder, who examined the same patient, also concluded that it was a case of ascites; but, on making an exploratory puncture, he found that we had to do with a cyst. I have known several instances of the same kind, and whenever one meets, in a woman, with what appears to be an ascites the cause of which is at all obscure, one ought always to think of the possibility of its proving to be an ovarian cyst.

There exists a symptom which is of considerable assistance in arriving at a correct diagnosis; in a true case of ascites the fluctuation can generally be perceived in the vagina, whereas never anything of the kind occurs in cysts.

**Diagnosis and Treatment of Ureteritis in Women.**—Dr. Edward P. Reynolds, Med. Surg. Bul., says that the two most characteristic symptoms of ureteritis are: (1) Frequent micturition, increased by the erect posture; and (2) a bearing-down pain, increased on standing, but usually completely relieved by a few hours' rest in bed. Vaginal examination elicits tenderness and a desire to urinate on making pressure over the vaginal portion of the ureter. Cystoscopic examination usually shows gaping or redness and swelling of the ureteral orifice or of the adjacent mucous membrane. In eight cases of ureteritis in which he had catheterized both ureters it had been found that the percentage of urea was in every instance decreased in the urine obtained from the diseased side. Where the ureteral orifice and adjacent vesical mucous membrane were inflamed, relief would usually follow the strictly localized application of solid nitrate of silver. The patient should be made to drink three or four pints of water, should avoid asparagus and strawberries, and should partake sparingly of other fruits and the highly flavored vegetables. This condition, he thought, was often mistaken for renal colic or for acute catarrhal salpingitis. At the beginning of the attack there would be renal tenderness on deep pressure, and later on there would be tenderness located at McBurney's point. Still later a new spot of tenderness would be found at a point about one inch above Poupart's ligament.

## Obstetrics.

***Sulphate of Quinine in Labor.***—Dr. Schwab (Revue Obstét. et Gynéc.) praises the efficiency of quinine as an oxytocic. Whenever he has given it in the course of simple lingering labor it has awakened or accelerated uterine contractions. Quinine stimulates uterine fibers when once they have begun to contract of their own accord. Like ergot, it does not set contractions going; hence it is not an abortifacient. Quinine has one distinct advantage over ergot; the contractions which it sets going retain their normal intermittent character. It acts rapidly—within twenty-five minutes, as a rule. Large doses are needed; a gram, that is,  $15\frac{1}{2}$  gr. in two “cachets,” taken at an interval of ten minutes. These two doses of sulphate of quinine are given, particularly when the membranes are ruptured and it is advisable that the labor should be ended as soon as possible. It is harmless to mother and child alike, since, should it fail, dilators or forceps may be used, and there is no difficulty from the tonic contractions caused by ergot. It should be remembered that, as the placenta comes away, when quinine has been used there is a slight tendency to internal hemorrhage. Coules, as long ago as 1888, advocated quinine in abortion with retention of fetal relics. Schwab has given the drug in three such cases with good results, being quickly expelled, but he cannot feel sure how far the quinine contributed to the good result until further experience. Of its direct value in labor he has no doubt.

[It is in such cases as these, lingering labors, where the contractions of the uterus are inefficient, that cinnamon may render excellent service, increasing and strengthening the contractions, which still retain their intermittent character, as the following case well illustrates:

Mrs. W. Sixth pregnancy. In her first pregnancy, pains were weak and inefficient, head did not engage, so that she was finally delivered with the aid of forceps, and ergot given to cause contraction. As a result she was badly lacerated, the os being torn and the perineum torn to the anus. Second pregnancy; de-

livery of a similar character; pains inefficient; craniotomy. Third pregnancy; delivered after a long and painful labor, by the aid of forceps. Fourth and fifth labors were more satisfactory, although forceps were used in both cases. Sixth labor began on Thursday afternoon with sharp contractions and bearing down pains, coming at intervals of ten to fifteen minutes and lasting a few seconds. These continued all night, but with diminished force. Puls. was prescribed, but without apparent benefit. Pains of the same character all day Friday, and Friday evening. Examination showed os well dilated, position o. l. a.; the pains were just sufficient to bring the head upon the superior strait, but as soon as it was about to engage they would pass off. At midnight began giving teaspoonful doses of decoction of cinnamon every fifteen minutes. After the second dose pains grew stronger and lasted longer and continued to increase in strength and frequency, so that the child was delivered at 3 A. M., without forceps and without laceration. Uterus contracting well after removal of placenta.—EDITOR.]

***Chloroform in Labor.***—Dr. Richard Hughes writes us from Brighton: On p. 54 of the January number of your Journal, I find myself credited with a sentiment which is so foreign to my mind that I must ask you to be good enough to repudiate it on my behalf. I have never written to this effect. On the contrary, for the close upon forty years of my practice I have never refused my parturient patients the blessing of chloroform, and have never seen the least harm from it.

[In explanation of the above letter we would say that the Dr. Hughes quoted on p. 54, was not *the* Dr. R. Hughes, of international reputation, but a Dr. Hughes of America.—EDITOR.]

***External vs. Internal Examination in Labor.***—Dr. Ahlfeld (London Lancet) is not inclined to return to the use of the internal examination in labor, neither is he in favor of an extension of the exclusive employment of the external. He thinks that the purpose to be attained is the improvements of both external and internal methods of examination, and the employment of them both for the advantage of parturient women. It is pointed out that the external examination intra partum is difficult to perform, and can only be reliable in the hands of

specially skillful observers ; further, it only enables us to diagnose a small number of the anomalies in labor which may prove dangerous for the mother and child ; and, again, the external examination, even when properly carried out, does not altogether exclude dangerous disturbances in the progress of labor. Instances are given in which the diagnosis founded upon the external examination alone was erroneous, and became a source of danger—for example, in one case it was believed that labor had not begun, and yet it turned out that the cervix was fully dilated and a well-marked caput succedaneum formed. At the same time the risks of the internal examination are well known ; and therefore Ahlfeld sums up the matter in the advice given above—namely, to use and improve both methods.

**Ovariectomy in Pregnancy and Labor.**—Dr. Hohl, Archiv. f. Gynäk.—In pregnancy ovariectomy should be performed during the first months, whenever possible. The question of inducing premature labor is to be entertained when the tumor appears to be very closely adherent or intraligamentous, so that ovariectomy would be of considerable gravity. Tapping must not be practiced. During labor the reposition in the abdomen of a prolapsed ovarian tumor should be effected as speedily as possible, under chloroform. Should the attempt fail, tapping is allowable in cystic or doubtful tumors. When there is a fixed tumor and the fetus is alive, and ovariectomy is thought inadvisable, or to be put off till the puerperium, Cæsarean section is indicated. He objects to the performance of ovariectomy during labor, followed by means to deliver the child. Ovariectomy, when no grave symptoms are present, should be undertaken as soon as possible during childbed, in the second week at the latest.

**Time of Rupturing the Amniotic Sac in Labor.**—Atlanta Med. and Surg. Jour. gives the following rules : 1. In multiparæ, rupture when the os is fully dilated. 2. In primiparæ, delay until the soft parts are also dilated. 3. In cases of face and breech presentation, delay in rupturing the sac is best. 4. When the pelvis is small and the fetus large, delay rupturing. 5. In premature labor, with a dead fetus, rupture early. 6. Rupture the sac early when the membranes are unusually thick, tough, and unyielding. 7. When speedy delivery is demanded, rupture

early and dilate with the fingers. 8. Rupture the sac when an excessive amount of amniotic fluid retards labor. 9. When version is necessary, and can be accomplished by bimanual manipulation, perform this operation before rupturing. 10. Remember that a dry labor is always to be deprecated; hence do not rupture at all, unless for good reasons and the case demands it.

**The Obstetrical Treatment of Puerperal Eclampsia.**—Dr. P. Drejer, Norsk. Mag. f. Laegevidensk.—The best treatment in puerperal eclampsia, both for mother and infant, is speedy delivery, whether labor has commenced or not. The best method of doing this is that which any medical man can employ, and for this and other reasons Dührssen's plan (by incisions) is not recommended, but simple dilatation. Hegar's dilators are used in the first instance; then, when the cervical canal will admit one finger, the rest of the dilatation is carried out manually, and delivery is completed by the method of Braxton Hicks. The colpeurynter is not much used in Norway, for the marked variations in temperature are apt to interfere with caoutchouc dilators. Bimanual compression is applied to the uterus for about one hour after the removal of the placenta, and so hemorrhage is prevented.

**Puerperal Inversion of Uterus.**—Dr. Devet (Monats. f. Geburtsch. u. Gynäk.) favors vaginal extirpation in irreducible inversion, especially when complicated with severe pain or repeated hemorrhage, stinking fetid discharge or inflammation of the appendages or parametrium. Périer's elastic ligature treatment, the most improved method of the oldest way of managing an inversion, is perhaps allowable to the practitioner without experience in vaginal surgery. The mortality, however, is rather high, and the after-treatment painful and tedious. Vaginal hysterectomy remains the best way of dealing with irreducible inversion. By adopting Doyen's method of making a median incision through the uterus, the danger of damaging intestine which may lie in the abnormal pouch made by the inversion is avoided. Henrotay attended a woman, aged twenty-two, who had been normally delivered by a midwife some few months past. Four weeks after delivery constant and severe flooding set in. She had become very anæmic. The os externum formed a sharp ring, through

which a tumor could be felt. The speculum was applied, and the surface of the tumor was seen to be uterine mucous membrane. All attempts to reduce the uterus having failed, a physiological salt solution was injected, and vaginal hysterectomy performed in twenty minutes, inclusive of the closure of the peritoneum. Henrotay objected to abdominal hysterectomy, and thought that all attempts to reduce the uterus through an abdominal incision would prove useless and involve danger. The operation actually performed proved easy, and was quite successful.

*Colostrum in Normal and Ectopic Pregnancy.*—Gessner, Zeitschrift f. Geburtsch. u. Gynäk., exhibited before a German society two specimens of secretion from the breast of a woman who underwent operation for tubal pregnancy at the third month. The first sample was taken from the breast on the day of the operation. It consisted of colostrum, as is found in normal pregnancy at the same date. The second sample was taken from the same breast five days later. It was clearly perfect milk. Gessner insists that this phenomenon, even earlier than the third month, is an infallible sign of the death of the ovum, and he has noted it in a long series of uterine pregnancies.

*Twins from a Single Ovule.*—Dr. Stephenson (Brit. Med. Jour.).—On November 8 I was called to attend Mrs. W., aged twenty-eight, in her third confinement. On examining her I found the head presenting; I ruptured the membranes, and in a short time delivered her of a well-developed male child. On placing my hand over the uterus to express the placenta, I felt a second child in utero, and on examination per vaginam found another head presenting. I immediately ruptured the membranes, and about a quarter of an hour afterward delivered her of a second equally well developed male child. On carefully examining the placenta after expression I found two placenta in close apposition, fused into a single mass, a separate cord to each almost joining at their insertion; the vessels of the one appearing to anastomose with those of the other. The whole placental mass was surrounded by one chorion, inclosing two distinct amnions. This was evidently a case of twins developed from a single ovule containing a double germ, a condition I believe to be somewhat rare, and conformed to the rule laid down by

Schroeder, that in these cases the children are always of the same sex, and generally males.

Although both fetuses were exceptionally well developed, presented by the vertex, and were inclosed in a single chorion, there was not the slightest difficulty or delay in the birth of the first child.

On inquiring into the family history I find the patient's mother had only one child, her husband died six months after, and she did not marry again ; but the grandmother gave birth to twins, both of which were females.

**Prevention of Puerperal Convulsions.**—J. N. Upshur records, Virginia Med. Semi-Monthly, five cases illustrating the prevention of puerperal convulsions. He emphasizes the necessity of the early engagement of the medical man by the patient and his subsequent close supervision of the case. The urine may yield negative evidence, but severe head symptoms (headache, vertigo, etc.) and a hot dry skin may warn us of danger. Excessive eating and overloading of the stomach are exciting causes. The preventive means are care of the diet, regular exercise in the fresh air, and special attention to the bowels and kidneys. In the attack Upshur recommends chloroform, bleeding, and active purgation, with prompt delivery of the child. If the patient remain unconscious after delivery, with symptoms of depression, a hypodermic injection of strychnine nitrate will do good by sustaining the heart, diminishing the cerebral congestion, and keeping up the contraction of the uterus ; morphine is positively contra-indicated.

**Hysteria Simulating Eclampsia in Pregnancy.**—Dr. Bes-carlet, L'Obstétrique, reported at the Geneva Congress the case of a pregnant woman, who caught cold and inflammation of the kidney ensued. The fetus died, and several convulsive attacks followed, which he maintained were purely hysterical. The chief positive evidence was their punctual recurrence at a certain time for several nights in succession. They differed from even mild eclampsia by the absence of vomiting, coma, deranged vision, and facial convulsions.

**Ovarian Abscess after Delivery.**—Dr. Bröse, Berl. klin. Woch.—A woman after confinement had high temperature, which subsided, but the severe pain which accompanied it con-

tinued till the end of three months, when he operated. Both appendages were removed. The right ovary was converted into an abscess larger than a walnut, the left contained a smaller amount of pus. The left tube was also suppurating. The temperature had been normal just before the operation. Recovery was rapid.

**Hasty Delivery of the Fetus a Frequent Cause of Post-Partum Hemorrhage.**—"Post-partum hemorrhage dependent upon pathological conditions of vascular, nervous, or muscular systems is comparatively rare, and when due to other causes is the result of inefficient management." It may be caused by manual or mechanical dilatation of the os and by "stimulation of contractions by forcible manipulations or by drugs having similar action." These measures are often proper, but when unnecessary or too much used they are dangerous. They tire the uterus so that it cannot shut down on the open blood vessels when the uterus is empty. Too speedy placental extraction is another cause of hemorrhage. Generally, no effort should be made to remove the placenta till after fifteen minutes. The uterus should be kept under observation to insure continuous contraction sufficient to prevent bleeding. "When the hemorrhage is very profuse and immediate death threatened, pack the whole uterine cavity firmly with the cleanest material at hand and use every means besides to excite uterine muscular contractions."

**Puerperal Eclampsia.**—Dr. S. S. Jones.—It would seem that one is justified, after weighing all the best available opinions, in concluding :

That puerperal eclampsia is due mainly to the non-elimination from the system of the pregnant woman of toxins which are the direct and natural product of the physiological processes incident to her condition, or to the conversion into toxins of such products and their non-elimination, and that the nervous tension of the pregnant woman predisposes to the disease.

That while albuminuria during pregnancy should lead to grave apprehension, yet many women who present this symptom escape convulsions (about seven out of eight), while convulsions may be met with in women whose urine has remained free from albumin until the onset of the convulsions.

That he who saves four out of five women who have been



attacked by eclampsia before or during labor may consider that he has been fairly successful.

That we have medicines powerful for good, and that they should be given a fair trial before resorting to accouchement forcé in actual convulsions.

That at a period when the fetus is viable, especially at the end of the eighth month, if the patient suffers from severe premonitory symptoms, such as anasarca, severe and persistent headache, and the eye symptoms, and particularly if the evidences of nephritis have persisted for some time in spite of treatment, premature labor should be induced in the interest of the mother and child.

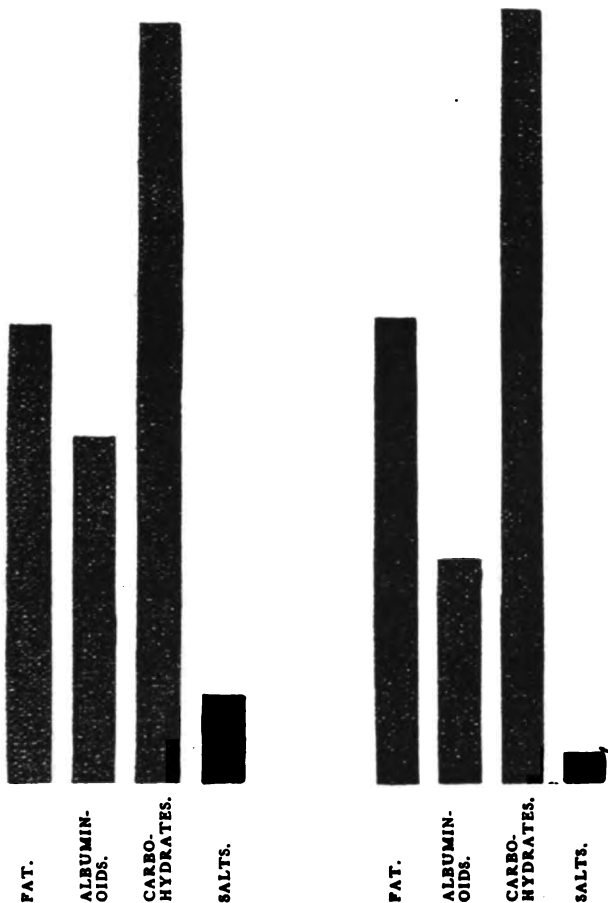
That in the actual presence of convulsions we should endeavor to overcome them by the use of proper medicines and remedial measures, notably by the use of veratrum viride, morphine, chloral, and chloroform, rather than appeal to the rapid emptying of the uterus.

*Hysteria in Children.*—Dr. Jolly (Archiv für Kinderheilkunde).—All the local manifestations of hysteria, the seizures as well as the real disturbances of the mind, are observed in children as well as in adults. We often see local disturbances and intractable pains confined to one region of the body (e. g., so-called neuroses of the joints) with which spastic conditions, such as paralysis and tremor, are frequently combined. Particularly are hysterical contractions and palsies observed in convalescence from acute and chronic diseases, when, after a long period spent in bed, the patient is urged to leave his bed and move about. Sometimes marked stuttering or mutism, either of short or long duration, is observed. In hysterical seizures highly increased emotional expressions are indulged in, spasms of screaming alternate with spasms of crying or laughing, and jactitation of the extremities occurs.

Hysteria does not originate in the uterus; its manifestations make their appearance long before puberty, in the boy as well as in the girl. There is no doubt that genital excitation (particularly onanism) does sometimes play a rôle in its production, but the main ætiological factor is always an inherited neuropathic disposition, and this, together with debilitating diseases, poor nourishment, anæmia, and an immoral education may lead to hysteria.

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Fig. XVII—Dorsal Position.

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## ACUTE INFECTIOUS DISEASES IN THE GESTATIVE AND PUERPERAL STATES.

By BENJ. F. BAILEY, M. D.

THE acute infectious diseases necessary to consider as threatening at these times of life are: scarlet fever, measles, typhoid fever, yellow fever, cholera, smallpox, erysipelas, pneumonia.

There are certain matters of consideration common to all of these diseases. In all cases involving a higher temperature the fetal circulation is weakened, the temperature of the fetus always runs higher than the temperature of the mother, as we record it, and also retains it longer, while the fetus is in turn less able to resist a high temperature than is the mother, and interruption of pregnancy usually ensues. In fact, in all of these infectious diseases abortion or premature labor is the common outcome. Some have attributed this to the high temperature, others to hemorrhagic endometritis—resultant partly from maternal hydræmia. Charpentier, Doléris, and Doré consider that they have proven that only when the elevation of tempera-

ture is abrupt is it marked in abortive effect. They therefore claim only a secondary effect from hyperpyrexia. Slavjansky has apparently demonstrated that the interruption of pregnancy in cholera is due to hemorrhagic endometritis, but Quierel in his investigations of cholera at Marseilles could not affirm this, neither could Klotz in his study of measles in pregnancy. Others, among them Charpentier, claim the interruptions of pregnancy in these cases are due to toxæmia of the fetus. Klotz, of the University of Innsbruck, is positive that hemorrhagic endometritis is not proved in measles, scarlatina, variola, erysipelas, or typhus. Zwiefel believes the great increase of temperature, acting upon the nerve centers, produces uterine contractions. Probably, however, Charpentier's toxæmic theory has at the present time the most adherents, and though fetal toxæmia may not in all cases be the sole cause of the interruption of pregnancy it is probably a most important factor in all cases.

Considering the diseases separately, scarlet fever does not often attack women during pregnancy, but during the puerperium there is supposed to be an especial tendency to infection. It is even believed by some authorities that puerperal patients are so susceptible to the scarlatina poison that, if exposed, they suffer even though they have previously had the disease. It would thus appear that women in childbed have a liability to second or third attacks. Busey relates one case of this kind, and there are others of record.

Olhausen says that he has collected 7 cases of scarlet fever occurring during pregnancy, and 134 during the puerperal state. This, as well as some other records, leads us to believe that we have sometimes during pregnancy infection with scarlet fever and a prolonged stage of incubation, the disease not really manifesting itself until the puerperal state. In these cases pharyngitis and tonsilitis are usually very mild or absent. Diarrhea is a common and most

dangerous symptom; lochia, milk, and involution seem unaffected. In certain series reported Denham saw only 1 recovery in 8 cases, Hicks 4 in 18; McClintock only lost 10 out of 34. In cases occurring during the first week of the puerperal state the fatality is excessive; even as high as sixty-six per cent. After the first week, or late in it, the fatality decreases. At the same time that there is supposed to be marked susceptibility to this disease, it is well to bear in mind there are well-authenticated cases where women have been confined in the room, and even in the bed, with scarlet-fever patients without injury. Further than this the assertion may be made that without question the present records are very unreliable, and that many cases have been declared to be scarlet fever when they were simply septicæmia. From the absence of some of the typical symptoms of scarlet fever, where it occurs in the puerperal state, some have claimed that infection with scarlet fever induced septicæmia, while others have claimed that the supposed cases of scarlet fever were not scarlet fever at all, but merely septicæmia with an eruption simulating scarlet fever. Olhausen and Braxton Hicks have especially discussed these theories pro and con. Probably neither theory is a universal one, and the diagnosis in each case must be settled by the history and surrounding conditions. Has there been a disease *sui generis* near by—can infection from such disease be traced—or, on the other hand, is there evidence in lacerated surfaces, retained *débris*, or changed discharges of possible septic infection?

In any case of doubt it is in my opinion a wise procedure to thoroughly irrigate the uterus and, in some cases perhaps, practice curettement. Of course this should be done with great care, and, if so done, we probably remove all possibility of further septic infection and incidentally lower the temperature of the patient. Braxton Hicks claims, and probably with good reason, that the earlier the symptoms occur after confinement the more fatal is the



disease. I find very little literature upon measles in pregnancy, and attribute this largely to the fact that it is rather uncommon in occurrence, not so commonly fatal as scarlet fever unless accompanied by pneumonic exudation, and it is then almost universally fatal. In a moderate per cent. of cases it results in an interruption of pregnancy. In the cases about which I have been able to gather some information the patients have been very sick, but have recovered and gone on to a normal parturition. It is, however, believed to have a large fatality, if occurring at the time of parturition or immediately thereafter, although Underhill claims that it is more fatal when occurring after confinement than when confinement occurs during the disease. Two cases are reported by Nelson of St. Louis and Chantier of Geneva in which the mothers were safely delivered, though suffering from measles at time of delivery. It seems to be the prevailing opinion that, if the mother passes through the measles after the fifth month and goes on to successful confinement, that the child will probably be immune. Children have been born with well-developed eruption. Probably the rarity of pregnant cases both of scarlet fever and measles is due to the fact that nearly everybody has suffered from the diseases during childhood.

Pregnant women are especially prone to variola and varioloid. The cases of varioloid have a good record, usually result favorably, and in many instances the child has been found insusceptible to vaccination, hence probably immune to smallpox. Variola vera runs an exceedingly severe course and usually results in abortion and death. The fetus may have all stages of the disease *in utero* or may be expelled at any stage of the development of the disease in its own little person, or it may be expelled early in the mother's disease, only to develop it soon after its birth. There are cases upon record where children have been born with variola, the mother being apparently healthy. This has given rise to the supposition that the

mothers may at times have the disease without eruption. A mistaken diagnosis is, however, the more probable explanation—vaccination of pregnant women has caused infants to prove insusceptible to vaccination. Speigelberg claims that variola is the only infectious disease in which the fetus becomes infected *in utero*. Speigelberg also says it is a peculiar fact that during epidemics of variola there are at times epidemics of puerperal hemorrhage, though unaccompanied by the breaking out of the eruption in either mother or fetus; though it is believed that these hemorrhages are consequent upon variolous infection.

Of all the infectious diseases the pregnant woman is the most sure to be attacked by cholera during epidemics of this disease; she is most liable during the sixth and seventh months. Of those attacked sixty per cent. are said to abort. Of those who abort about sixty-six per cent. die. Of those who do not abort fifty per cent. die.

Bemiss states (and most other authors coincide with him) that yellow fever is quite apt to infect pregnant women, and especially those in childbed. It is also stated that if a pregnant woman suffers with yellow fever and recovers without the interruption of pregnancy, the child is protected from further susceptibility to the fever, which somewhat strengthens the claim that toxæmia of the blood of the fetus takes place through the passage of the maternal blood to the fetus.

Murchison thinks pregnancy offers no exemption from typhoid fever. Rokitsansky and Niemeyer thought it did. In the cases on record, so far as I can find, in those occurring any time after the first months abortion has ensued, though patients seem to stand about as good a chance for eventual recovery as do non-pregnant cases. Erysipelas is not common during the pregnant period, but the lying-in woman is easily infected, and when once the disease develops it is like wild-fire, general sepsis and death usually following.

The last disease to consider is pneumonia. Some may question if this properly belongs to the series of infectious diseases. The pneumococcus seems now, however, to be generally recognized, and I find the latest writers include pneumonia in the infectious list. Pneumonia occurring in a well-developed case of labor the outlook is of the worst. Happily it is not a common complication of pregnancy. Its course is somewhat peculiar to this condition. The temperature is quite apt to run exceedingly high and to be very unmanageable—after two or three days' pains commence and the uterus is promptly emptied. This is followed by a lower temperature and pulse and subjectively a generally better feeling, and it is well to be careful lest we be deceived. If we carefully examine the chest, the same local lesion will be evident. Within eighteen hours the temperature will again soar skyward, the pulse become more rapid, the respiration hastened, and if we now examine carefully we will in most cases find an increase in hepatization. The case will go from bad to worse, and a very heavy per cent. of cases die about the end of the third or fourth day after the uterus is emptied; this when the disease attacks after the fourth month. Before that, though a serious complication, usually resulting in abortion, yet it is not nearly as fatal. Strange to say, during the course of the disease, after the interruption of pregnancy, neither the lochia nor the lacteal function seem noticeably affected.

In closing, let me say these diseases are not common complications of pregnancy, and for this very reason we do not often consider them. But when they do come they are disastrous, and it is well that we should be cognizant of the usual trend, else we may be unfortunately surprised.

## TWO CASES OF PUERPERAL PERITONITIS.

BY E. F. A. DRAKE, M. D.,

Professor of Obstetrics in Denver Homeopathic College and Hospital.

UNTIL within the past six months I have been able to boast that not one parturient of whom I had had the care had been afflicted with puerperal fever in any of its varied forms; but I am learning, as I get farther away from youth, that it is vain to make one's boast of anything earthly.

In January last I was engaged to attend Mrs. S. in her second confinement, which she stated would occur the second week in April. She was a delicate, refined little woman, of rare common sense and judgment, and I found had taken the best of care of herself from the supposed beginning of her pregnancy. She was a typical puls. patient, and in preparation for her confinement I began giving her this remedy about the middle of February.

Her first labor five years before had been protracted and difficult, and her getting up slow; consequently she looked forward to this confinement with grave apprehensions. On the night of February 28 I was called to see her, the messenger telling me that they feared a miscarriage.

On reaching her bedside I found labor well advanced and everything progressing in the most approved manner.

In less than an hour after my arrival she was delivered of a fine boy, hardly giving me opportunity to exhibit the comfort of the anæsthetic which I had promised her.

The third stage was soon over. She was made comfortable, and very happy that her delivery was so safely and easily accomplished.

All went well until the third morning, when, following a slight chill, her temperature ran up to a fraction above 100°, and her pulse quickened to 110 per minute.

On examination I found no abdominal or pelvic tender-

ness, and no change in the character or quantity of the lochia, which was in every way normal.

On the evening of the same day her temperature registered  $102^{\circ}$  and her pulse was increased to 115. The milk had appeared but with no rush, there being scarcely enough to satisfy the baby. She did not count this strange, as with her first child she had had almost none at all.

On Wednesday, the fourth day, her temperature was  $103\frac{1}{4}^{\circ}$ , her pulse 120, while she was suffering intensely from pain in the back and limbs, severe headache, and photophobia. She was very restless, having slept but little the night before. In the morning all her symptoms were aggravated, and yet with this perfect picture of puerperal sepsis, there was wanting this first untoward change in the lochia, and no abdominal or pelvic tenderness.

On Thursday morning still an aggravation of symptoms, temperature  $104\frac{1}{4}^{\circ}$ , pulse 130, and yet no clew to the cause. The aching in back and limbs had been almost unbearable during the night, and only slightly relieved by hot applications.

In the afternoon the secret was out, for I found my patient well broken out with measles, with this anomaly, the rash appearing first on the chest, afterward on the face and body.

She had from the first excellent care, from a sister who had providentially arrived on a visit the day before my patient's unexpected confinement.

The sister was herself pregnant; and had been confined to her bed for weeks previous to her coming down from the mountains, on account of excessive nausea and threatened abortion. She was very anxious to carry this child, but feared it would be impossible, as she had miscarried twice already at about this period. Her nausea had been greatly relieved by the exhibition of *nux vomica* 30x, and all promised well.

My measles patient made a splendid recovery, and on

the ninth day, Tuesday, was allowed to sit up in bed, and at the end of two weeks was dressed and about the house a little.

Tuesday morning, on making my visit, I was confronted with the sister's threatened abortion, having had a night of uneasiness and pain, followed by not profuse flowing. She thought everything was over, mistaking some clots for the fetus. On examination I found the mistake, and still hoped the miscarriage might be averted. An excellent nurse was obtained and strictest orders given, but before I could reach her in the afternoon, she had nearly succumbed to flooding. From the beginning of her pregnancy she had had extreme pelvic tenderness; this and a marked ante-version made examination very difficult, every attempt causing fainting.

Ipecac relieved both the severe flooding and a distressing nausea, and gave me time to nourish her with strong beef tea and gruels before making further effort to empty the uterus. I found the os slightly dilated, and the membranes still intact. Only after repeated efforts did I succeed in dilating sufficiently to allow the passage of the fetus and secundines. The flowing soon ceased and my patient was resting quietly.

On the second morning, however, she accosted me with "Well, doctor, I haven't measles, but a real miserable attack of grippe. The pain began in the night in my head and face, went into the right breast and side, and finally located in the right side of the bowels." I allowed her to think it grippe, but I said mentally, "If it is nothing worse than that I shall be thankful."

There was less pelvic tenderness than before her miscarriage, and no indication from the lochial discharges that a shred of the membrane had been left behind. I gave her ferri. phos. 6x, and the nurse careful directions, but on my afternoon call found her temperature 104° and a fraction, with a pulse between 120 and 130, abdomen puffed and

exceedingly painful, and a severe right-sided sciatica which had attacked her at each of her previous miscarriages; tongue brown, severe headache, a distressing tenesmus, frequent but small evacuations, relieved by copious warm water enemas. Kali. phos. 12x was given in alternation with the ferr. phos.

There was yet no marked metritis, the septic position seeming to spend itself on the upper right abdomen.

I have neglected to say that every precaution against sepsis had been used with both my patients from the outset. Permanganate of potash in all the receptacles about the sickroom, while listerine and calendula were freely used in the douches and enemas.

The house was small, having but three rooms below stairs, double parlors, and a kitchen. The back parlor was the sleeping room of Mrs. S., my first patient, while Mrs. B., the sister, occupied the front parlor. The upstairs rooms were unfinished, hence isolation or even separation was impossible, as only portières separated the two parlors, and both were heated by one stove.

On Thursday night, a little after midnight, I was called up to see the baby, which had, up to the morning previous, been a model of quietness and good behavior, eating and sleeping with no intervals between. On giving it its sponge bath that morning, the nurse had reported a slight rash, which disappeared in a few hours, and as the baby seemed perfectly well, little was thought of it, save the administration of a few doses of bryonia. It seemed well through the day, but restless in the early evening. When I reached there, the nurse had exhausted her energies, and "couldn't imagine what was the matter with that good baby." It was natural to look for indications of measles, but nothing appeared outwardly. On examination I found the left scrotum very red and slightly swollen. The abdomen was already quite sensitive and bloated. Suffice it that the little one, despite everything that could be done, suc-

cumbed the fourth night with every evidence of mucous enteritis from metastasis of the measles to the mucous linings.

The little mother, unable to do anything for the relief of her baby, had gone that night, very imprudently, to a cold room to sleep, and being called up to nurse the little one, was taken with a severe chill, and on my arrival in the morning I found *her* in a high fever, face scarlet, abdomen sensitive and already quite painful, very much depressed in spirits, in fact, "knew she must die," and I confess that I had my fears that she was right.

The sister was then at the worst; had slept but very little for two nights and days; being unable to shut out the moans of the little one.

Failing utterly with other indicated remedies, and knowing that sleep must be had, I gave two  $\frac{3}{4}$ -grain doses of sulphate of morphia two hours apart, which induced a quiet, restful night, and gave her strength to rally her forces for recovery, which from this time on was rapid and uninterrupted. Just one month from the day of her miscarriage, she came to my office to begin a course of treatment, hoping if she could get perfectly well, she might yet carry a child to full term.

As soon as at all advisable I had her moved to a brother's in another part of the city, as I feared the worst for the little mother in this post-*puerperal* attack. Her pulse ranged from 110 to 130, and temperature from  $103^{\circ}$  to  $104\frac{1}{2}^{\circ}$  for several days, before it could be controlled. In this case as in the other, the uterus was but slightly affected, involving only the peritoneal covering of the right side. The left side of the abdomen seemed comparatively free. The pain and tenderness on the fourth day localized in the ileo-cæcal region, and became almost unbearable, when, following an enema, for two hours there were involuntary stools of mucus, slime, and stringy membranous shreds (proving the enteric sympathy with the suffering peri-



toneum) mixed with a small amount of fecal matter. This gave almost instant relief, and, while very weak, her recovery began at once and continued uninterruptedly. Her remedies from the onset of this attack were aconite, followed by bell., both in the 30x, while the sister's symptoms called for ferr. phos., which was followed by kali. phos.

Both patients, after the subsidence of the fever, were distressed with a troublesome proctitis accompanied by tenesmus. This symptom was speedily overcome by merc. viv. 30x.

But my chapter of difficulties is not yet recited. During the illness of Mrs. S. the husband was prostrated with one of the severest attacks of tonsilitis I have ever witnessed (in former years a frequent ailment with him), but this time a most purulent attack of ozena accompanied the tonsilitis. The attack reached its height the day before the death of the little one. A brother of the ladies also suffered for two days with a severe sore throat, and the husband of Mrs. B. filled up the chapter with a day and night of vomiting and diarrhea; the nurse, of all the family, only escaping.

When my patients began to multiply I began to search further for a possible cause about the house for all these calamities.

In an outer inclosed porch where the ice chest was kept, was a barrel for water which was brought from a hydrant a few rods away. Knowing the possibilities residing in such a barrel, and fearing something might have fallen into it in transit from the ice chest to the kitchen, it was emptied and discarded for the time being. This was the only discernible thing about the place at all objectionable.

The cause of the fever I believed in the first instance was largely autogenetic. From the constant nausea and depleted condition previous to her miscarriage, and great blood loss following, she was an easy prey to any poison that may have been lurking about either within or without. That it was not due to any carelessness of physician or

nurse at the time or following the abortion, was to my mind evidenced by the absence of metritic inflammation or other involvement.

The little mother's may have been a case of contagion, and probably was, though I believe except for the anxiety and sorrow at the sickness and death of her child, she would have escaped the post-puerperal attack.

That there may have been some few millions of heterogeneous microbes, harmless, and otherwise, lurking in the depths of that water barrel, and elsewhere, is admitted; but just why they should have attacked my second patient and not my first, immediately following her confinement, is difficult to determine; also just why they should have left the uterus unharmed in both cases when used in douches, and vented their fury upon the abdominal viscera through enemas, is a question I shall not attempt to settle.

To quote from a good authority, "The particular influences which singly or in combination may lead to puerperal fever in any given case are not always assignable. Sometimes this disease appears to rise spontaneously, and without our being able to attribute it to any cause whatever. In such cases therefore we are driven back to first principles, and compelled to seek in some profound dyscrasia of the individual constitution, or, in what may be nearly the same thing, some hitherto unmanifested exhaustion of the patient's system, for the sufficient cause of an attack which may prove as rapidly fatal in its termination as it was sudden and unforeseen in its attack."

To recapitulate: My first case of septic fever, the case of Mrs. B., who miscarried, was purely of autogenetic origin. Her depleted condition from the excessive nausea and vomiting following conception, together with the chronic pelvic disturbance, with the mental anxiety caused by the critical condition of her sister and baby, gave her little strength to carry her safely through the always to be dreaded miscarriage.

The little mother, the second case, would, I feel confident, have pulled through without her post-*puerperal* attack, had not this chain of anxious events environed her, and rendered her physically unable to throw off the possible contagion of her sister's fever.

The other sicknesses of the adults in the home were coincidences; each of the patients being subject to similar attacks, and at this time rendered peculiarly susceptible by watching and anxiety. That they all recovered save the little one is but another evidence of the power of homeopathy over disease under the worst possible conditions.

That the two childbed cases were circumscribed *puerperal peritonitis* is as unquestionable with me as that homeopathy has ability to cope with the dreaded disease.

I quote from an old-school book on obstetrics, of recent date, a wail that finds no answering chord in homeopathy:

"In considering *puerperal peritonitis* from a surgical standpoint, it is essential to note the change in practice which the last decade has witnessed, without, however, it must be confessed, any special change in results. It is a fact beyond dispute that, no matter what the form of treatment employed, the vast proportion of *puerperal peritonitis* patients die. Large doses of opium, saline catharsis, abdominal section, each of these approved methods has an exceedingly high mortality percentage."

While the mortality percentage is high enough under any method of treatment, yet we feel a measurable degree of pride in the returns of homeopathy in its battles with this always to be dreaded disease.

## GONORRHEA IN WOMEN.

BY M. BELLE BROWN, M. D.,

Professor of Diseases of Women, New York Medical College and  
Hospital.

**W**ITH the advance that has been made in all departments of medicine and surgery during the past quarter of a century, no more brilliant achievements have been made than in the treatment of the diseases of women.

The numerous and varied ailments to which women are liable have given a broad field, not only to the general practitioner for the exercise of his skill, but to the surgeon as well. The number of lives that have been saved; the number of conditions once considered incurable that have been cured; the vast number made comfortable, if not cured, by the modern methods of treatment, form a record in the making of which everyone interested in the subject and working along these lines is glad to have contributed even in a small way.

My attention was recently called to an address delivered in this city by an eminent gynecologist, wherein he stated, that "forty years ago, when the Woman's Hospital in the State of New York was built and devoted to the surgical treatment of diseases peculiar to women, no similar institution existed or had ever existed in any part of the world, not in England, France, Germany, nor in any country of Europe. To-day there are in New York City alone twenty-five public hospitals devoted in whole, or in part, to this special work; while similar institutions exist in Brooklyn, Jersey City, Albany, Buffalo, and almost all the cities of the State. The same statement holds good as to the large cities of our whole country: Boston, Philadelphia, Chicago, Cincinnati, St. Louis, San Francisco, and others too numerous to mention. Now add to these the cities of Europe: London, Paris, Berlin, Vienna, and St. Petersburg." If

along with these public institutions we sum up the numerous private sanitariums for the exclusive treatment of diseases of women, what an array of hospitals for sick women! More than for any other one class of ailments of the whole human race. Do you pause and ask what it is that is ravishing one-half of humanity as to make so many of these institutions necessary? One would think that a pestilence more devastating than war was selecting women for its victims. With all the advancement that has been made, can "our hearts swell with honest pride" as we contemplate the sum of human misery contained within the walls of these various institutions? We may take pride in the institution, its work, its brilliant operations and its small percentage of deaths, but in the next forty years I hope we can take greater pride when we can say the number of hospitals for the treatment of diseases peculiar to women has been reduced to less than half.

Prevention of disease along this line must engage the attention of the medical profession.

The pertinent question now is, can any, or how many of these ailments of women be prevented?

This brings me to the subject of my paper.

In every age someone constituting an advance guard proclaims some new truth or discovery which only becomes finally recognized through derision and opposition.

The first physician to bring the subject of gonorrhea in women before the medical profession was Dr. Emil Noeggerath in 1872. Only extracts of his little work, entitled "Gonorrhea in the Female Sex," were translated into English, but he stimulated investigation into the cause, diagnosis, and treatment of many of the coarser and more profound ailments of women. It was not, however, until seven years later that Neisser discovered the gonococcus, and thus confirmed the theory promulgated by Noeggerath, but not for many years accepted by the medical world.

The most elaborate article that has yet appeared in Eng-

lish upon this subject was published in "Wood's Medical and Surgical Monographs," Vol. I. No. 2, February, 1889, written by William Japp Sinclair, M. D., of Scotland.

Until I read this article I was blundering along in a most unsatisfactory way with many patients. Until Noeggerath wrote, the view was held that the vagina was the chief seat of the disease, the relation between gonorrhea and uterine or pelvic disease not being known. When a woman suffering from a specific vulvitis and vaginitis began to show symptoms of pelvic inflammation, she was immediately informed "she must have taken cold."

Since reading Dr. Sinclair's article I have been able to watch a number of cases from their incipiency to the most complicated sequelæ, and can bear out both Doctors Noeggerath and Sinclair in every detail of their clinical experience, and fully agree with their opinion in that "gonorrheal infection in women gives rise to a group of diseases which by reason of their clinical interest, and social and moral consequences, surpass in importance every other class of ailments which claim the attention of the gynecologist."

I will ask you to bear with me while I recite the history of several cases :

CASE I.—A young man with an active gonorrhea was approaching his marriage. He took the precaution to ask the advice of his physican "if he could safely marry?" He was told to "go ahead, get some tablets of bichloride of mercury and a fountain syringe, and that no harm could come to his bride if she would use this antiseptic douche." He married and followed the learned (?) advice, but with what result? His wife was infected, and within a month was sick with what was convenient to call "inflammation of the bowels." From a young woman who was never sick she became a physical wreck.

CASE II.—This case was one where the woman was infected from a chronic gonorrhea or gleet. Her husband had, prior

to marriage, suffered from an unusually severe attack of gonorrheal infection. He considered himself cured, and was not, until several years after marriage, troubled with any discharge. He was temperate in all his habits, but on the occasion of a public dinner he drank freely of champagne and other wines. In forty-eight hours he had burning and smarting in urethra and, to his astonishment, a discharge. I was called to attend his wife two weeks after this occurred, and found her with a typical attack of gonorrhea; urethritis, vulvitis, vaginitis, with finally extension to endometrium, tubes, and ovaries. From a woman in good health she was left with chronic pelvic trouble, leucorrhœa, menorrhagia, oöphoritis, and reflex spinal irritation. I obtained the husband's history subsequent to the treatment of his wife, when he complained "that she did not seem to get well," and rather questioned if I knew what "ailed her."

I began to interrogate him about his physical condition in as modest a manner as I knew how, as to whether he had ever had any local trouble either before or after marriage. He denied in most emphatic and unorthodox language that he ever had any such disease. The situation was growing rather uncomfortable, when I recalled Professor Pratt's advice, "Never allow your patient to whip you." I had not made a microscopical examination for the specific micro-organism, although I believe they are not always in evidence, yet I felt morally certain of the correctness of the diagnosis, and my confidence in the fidelity of the wife gave me courage to say, "My dear sir, notwithstanding all you say by way of denial in regard to your own past and present condition, it does not influence me to change my diagnosis, and whether the trouble was contracted legitimately or not is not for me to say, neither does it change the treatment." I then obtained his history, as I have given it above. I realize the importance of being extremely careful in the matter of diagnosis. We

come in close touch with the most sacred relations in life, and it is as much our duty to respect and guard them as it is to treat the sick, but when our diagnostic acumen is called in question, or our professional skill doubted, what course are we to pursue? The peculiarities which are present in every case must guide the judgment of the physician as to the wisdom of acquainting either the wife or the husband with the nature of the trouble.

I have recited this case to verify what Dr. Neoggerath wrote, viz.: "That when an old urethral discharge is lighted up by use of stimulants or sexual excesses, an infecting micro-organism may be found."

Only one more case, and this I will give in evidence of gonorrheal puerperal fever.

If gonorrhea in a woman does not entail sterility, is she more apt to have puerperal inflammation than a woman who has not been affected by the gonococcus? I answer yes, this has been my clinical experience in a number of cases.

CASE III.—A young graduate from Vassar, and the only daughter of wealthy parents, married, soon after leaving college, a bachelor of about forty years of age, and known as "a man about town." Soon after marriage she was ill with the so-called "inflammation of the bowels" which, now that the profession is awake, is known in the majority of cases to mean some form of pelvic inflammation, and is very likely of gonorrheal origin, as it was in this case. One year later she became pregnant. By great care she went nearly to full term, had a normal delivery with every precaution taken by way of antiseptics and cleanliness. During the latter part of the first week of her lying-in the old slumbering tubal and ovarian trouble was relighted, and a long illness of pelvic inflammation followed. Sanger claims that "in the gonorrheal *post-partum* affection it is the salpingitis which produces the affection of the peritoneum." "The effect on the tissues invaded by the



gonococcus is to convert the soil attached into a suitable medium for the growth and development of pus organisms." \*

Holding this view, it requires no great stretch of the imagination to understand how, with the engorged condition of the blood vessels of the pelvis, and with hyperactivity of glands and lymphatics during the early lying-in period, a septic inflammation could take place.

When prophylaxis of the puerperium has been observed, and complete evacuation of the uterine cavity obtained, and we still have puerperal septicæmia, from where is the point of infection? I do not mean to infer that *every* case of puerperal pelvic inflammation that cannot otherwise be accounted for is due to gonorrheal infection, but I do maintain that every woman who has been infected with this specific trouble is in danger of "complications" following childbirth; and it behooves the medical attendant, in order to guard his prognosis and perhaps direct his treatment, to be on the alert regarding the cause. There is always some source of infection in every case, or some law violated. Nature never would impeach herself by entailing these severe puerperal pelvic inflammations as one of the legitimate risks of motherhood. Recognizing the existence of gonorrheal pelvic inflammation, what are its sequelæ that so destroy the integrity of the organs contained within a woman's pelvis? The order of occurrence of invasion is urethritis, vulvitis, Bartholinitis, vaginitis, endometritis (cervical or corporeal), salpingitis, peri-oöphoritis, pelvic peritonitis, and cellulitis.

Not every woman affected with gonorrhea will sustain the same amount of damage; when the case comes under early observation, and the nature of the trouble recognized, it may, in some cases, be arrested; in others the virulence of the attack may resist all treatment and the patient pass through the various inflammations just enumerated; if she

\* *Lancet*.

survives the conflagration she will sustain one or more of the following sequelæ: Post-urethral abscess, hypertrophied labia, abscess or cyst of Bartholine's gland, chronic endometritis, menorrhagia, dysmenorrhea, pyo- or hydrosalpinx, chronic ovaritis, fixation of the uterus, sterility, and many reflex ailments. I might also mention some of the more remote and later affections, such as arthritis, phlebitis, endocarditis, and conjunctivitis.

For years the profession has recognized a form of rheumatism called "gonorrheal rheumatism," wherein the gonococcus has been found in the joint effusion. Neither do the effects of this virulent poison end here. "Twenty-one per cent. of the blind in the State of New York have become so from the effects of ophthalmia neonatorum." The propriety of passing a law making it obligatory in public institutions, as well as in private practice, to instill a solution of silver nitrate into the eyes of the newly born, goes to show that medical men are awake to one of the most lamentable effects likely to result from an exposure to this contagion.

German military surgeons give "eighty per cent. of men comprising the German army as affected with gonorrhea; and that out of one hundred women who have married men with suppressed gonorrhea only ten will remain sound." To quote Sanger again, he says: "Of one-eighth of all cases of pyo-salpinx and other surgical diseases of women, gonorrhea is the primary cause." Seventy-five per cent. of the blind in the asylums of Great Britain are said to be due to gonorrheal infection.

To return to the local and later pelvic affections. The actual increase in malignant disease of the uterus in admitted by all gynecologists.

The question that presents itself to me is, is a woman who has had gonorrheal metritis more apt to have malignant disease of the uterus than one who has not? This much we all know, that whenever we get a departure from

health in disturbance of function with altered structure of tissue, we are more apt to get degeneration than where we have integrity of tissue with normal function.

Twelve years ago a case of gonorrheal metritis and cellulitis in a young unmarried woman came under my immediate observation; three years ago, or nine years after, she succumbed to carcinoma of the uterus. The age of this woman was far below that at which malignant disease usually occurs, and besides, no heredity of this dread disease could be traced in her remote family history. I was led by the circumstances of this case to believe the cause of the carcinoma was the pathological condition of the uterus and its surrounding tissue induced by the inflammation. The organ was sclerosed and locked in the pelvis by adhesions. With blood vessels imprisoned in this contracted tissue, menstruation was rendered irregular and scanty, and nutrition impaired, certainly a favorable condition for degeneration. While this is only *one* case, and perhaps like the solitary swallow which can scarcely be recognized as valid evidence of the approach of summer, yet it should call our attention to times and seasons, and in classifying disease should be given its proper niche.

I would go even a little further in regard to the remote effects of the specific disease, and suggest what seems to me a perfectly tenable theory. Might not some of these cases of appendicular abscesses that cannot be accounted for, be due to the invasion of the tissue surrounding the appendix by the mico-organism of gonorrhea? I do not know the proportion of men to women who have appendicitis, but I do not think I am very wide of the mark when I say, there are about four times as many men as women who have this so-called new disease, and it goes without saying that many more men than women have gonorrhea, ergo, is gonorrhea one of the causes of appendicitis? or is there an anatomical reason why men should more often have catarrh of this appendage than women? or that it

should be the receptacle in them for cherry stones, grape seeds, and fecal concretions? "If arthritis, bursitis, peritonitis, endocarditis, and pleuritis are all acknowledged as complications of gonorrhea, and are dependent upon the presence of the gonococcus, the organism being carried from the point of infection, to some distant part,"\* what is to hinder them selecting the appendix as an abiding place? Whether they migrate, the appendix is not so far away, or whether they are gathered up by the leucocytes and deposited in these different localities, we may never know. Neither do I know if the gonococcus has been found camping around or in the appendix, but the frequency of appendicitis in men, and often an unsatisfactory reason given for its existence, has suggested this thought to my mind. It is worthy of investigation. If this can be shown, we may not have as much difficulty in bringing about a better state of morals in our young men.

*Treatment.*—Until we can prevent this disease we must treat it. Here as elsewhere, there is no "specific treatment." I mean no one line of treatment that will meet all cases. What is the object in treatment? To destroy the micro-organism, is it not? How best to do this is still an open question. One physician will prefer a bichloride douche; another the application of silver nitrate to the mucous surfaces, and another the dry treatment of iodoform and boracic acid, etc.

Bacteriologists claim that gonococci can only be cultivated in acid media, and that it is for this reason they flourish in the urethra and vagina—and in the less violent attacks do not reach the uterine canal when the secretions are alkaline.

Following out these investigations I have used hot vaginal douches of phosphate of soda, followed by one of fl. ex. hydrastis, two drams to quart of water. I have never found any benefit from bichloride douche, nor from paint-

\* Dr. E. Einger, *Wiener med. Wochenschrift*.

ing the mucous membrane with silver nitrate. In fact I doubt very much the germicidal effect of any treatment unless the case is seen early. I use the alkaline douche and hydrastis the same as in acute inflammation from other causes. Preceding the use of the douche I place within the cervix a plug of lamb's wool, wet in the alkaline solution, to prevent the invasion of the uterine cavity. In giving the douche the vagina is ballooned by compressing the vulva around the nozzle of the syringe; this is done in order that the alkaline water may find its way into the folds of mucous membrane. I make no application to the urethra, neither do I irrigate the bladder for fear of carrying infection into this viscus, but instruct the patient to drink freely of alkaline waters, vichy, etc. The patient is better satisfied if taking medicine; the two I have mostly used are Merrill's fluid hydrastis and tinct. cannabis sat. All stimulants and highly seasoned food are forbidden. This line of treatment is kept up for ten days or two weeks, sometimes substituting for the alkaline douche plumbi acetatis with carbolic acid in tinct. opii. If the uterus and adnexa become infected the treatment is the same as for non-specific inflammation. If we have not arrested the disease in the easily accessible parts, we cannot do much by using germicides in the uterine cavity. Dr. Max Maddleuer says: \* "Neisser's gonococcus is capable of passing from the endometrium into the muscular apparatus of the entire uterus and setting up metritis gonorrhoea." If this is true, we cannot stay its progress by any local treatment. During the acute course of the disease the use of the curette should be condemned; if its use is resorted to in the later stages for the uterine discharges and leucorrhoeas, the uterine cavity should be irrigated thoroughly by a solution of permanganate of potash before using the curette—then always use the douche curette that all *débris* may be immediately washed away. Cauterize the endometrium with

\* *Centralb. für Gynäk.*, December 14, 1885.

equal parts of Churchill's tinct. of iodine and carbolic acid, pack with sterilized cording, and follow with a hot douche, placing a tampon moistened with fl. ex. bell. and glycerin, one-half dram to ounce, in close apposition to the cervix. Do not pack the vagina so as to interfere with the circulation, the depleting effect of the glycerin and the influence of belladonna on the circulation and nervous system will reduce to a minimum any tendency the operation may have to increasing or relighting inflammatory action. I do not repack the uterus. If uterine discharges continue after curettage, intra-uterine bougies of sulphate of zinc and carbolic acid are used until the case improves or is perhaps operated.

I would like to add a word in regard to the treatment of the vulvo-vaginal glands, if they become attacked. Excision is more often advised than any other treatment, for the reason that is impossible to reach the infection when it has penetrated these racemose glands. Before resorting to excision, I would recommend the local application of creolin and glycerin, one part to ten. I have seen many threatened abscesses in these glands aborted by this treatment, if faithfully applied several times daily.

Since the serious effects of gonorrhea in women have been recognized, the question of when may gonorrheics marry is being discussed by medical men.

Dr. Lowenhardt gives the following rules to the observed by physicians consulted by blenorhagics to gain medical consent to marry: "As the virulence of the urethral discharge depends on the presence of the gonococcus, the candidate should be subjected to numerous bacteriological examinations. A slight secretion is not sufficient, but the urethral mucosa must be irritated in such manner as to place it in analogous conditions to those which light up an indolent process."<sup>\*</sup>

<sup>\*</sup> *Journal des Connaissances Médicales.*

I quote the following from Dr. F. E. Doughty's "Genito-urinary Diseases," 1897:

Marriage and gleet.—"It is a dangerous thing for a man with a discharge to marry. The line should be drawn here very strongly, and permission given only when shreds have been examined again and again and no gonococci found. The discharge may have become translucent, with no signs of pus, yet pus makes its appearance twenty-four hours after marriage, and the woman be inoculated. And yet marriage is often just the thing the patient needs; it will stop the discharge, but the woman may be sacrificed."

*Prevention.*—Prevention of disease is largely occupying the attention of the medical and scientific world at the present day. The Pan-American Medical Congress which met November 15, 1896, in the City of Mexico is an association of medical men from all parts of the western hemisphere; and has for its object the promotion of medical science, the providing of means for studying precautionary measures to be taken against epidemic disease, and for obtaining uniformity in the nomenclature of disease in order to prepare tables of mortality.

If sanitary laws can diminish the number of tubercle bacilli floating in the air, smallpox be limited or prevented by vaccination, the inroads of the Klebs-Loeffler bacillus arrested by anti-toxin, the germs of typhoid and typhus annihilated by germicides, why not go further and prevent the amount of contagion afloat that is ruining not only the physical health of men and women, but is filling our hospitals with incurable victims, increasing mental and nervous diseases, inflicting blindness and untold misery upon thousands of innocent children, in fact, attacking the strongholds of our whole domestic life, destroying happiness and home?

The great era in the progress of gynecology will date from the establishment of any methods or measures that will minimize pelvic disease. Of course there will be

"female complaints" as long as female children continue to be born; the structure and function of the organs contained within a woman's pelvis renders her liable to many and varied ailments, but it is prevention of these serious diseases which she often has thrust upon her that we would offer for consideration.

Physicians hold largely in their hands the interests of humanity, and to them we must look to help reform the world, especially the morals of *young men*.

Moral reform cannot come from legislation. You cannot pass a law and make it effective without a good moral sentiment behind it.

It is to education in the home that we must look for moral reform. Fathers and mothers must first inform themselves, and then teach their sons and daughters some of these central facts of life. There should be no barriers between parents and children. Nature contains nothing indelicate in her secrets. Fathers should teach their sons, with all the emphasis of which they are capable, to shun all forms of evil. But who is to teach the parents? I answer, the family doctor. Physicians have too long considered gonorrhea as only a slight ailment, which was no bar to marriage. Until gonorrhea is cured it is as much a bar to marriage as syphilis, and until it is so considered, diseases of women will increase and hospitals for their treatment multiply.



## THE ERUPTIVE DISEASES IN PREGNANCY.\*

BY C. E. WALTERS, M. D.

THE expectant mother, who looks forward to her time of trial with fear and trembling, believes the physician into whose hands she commits her case to be fully qualified in every way to meet each phase and complication that may arise during her maternity and accouchement. The books tell us that these complications are many and varied. Some of frequent occurrence, such as nausea, pyrosis, constipation, etc., etc.; others, such as placenta prævia, abnormal presentation, eclampsia, etc., more rare.

Of all the complications, perhaps none are more to be dreaded by the physician than the eruptive diseases—variola, scarlatina, measles, and erysipelas. The laity have come to understand their serious significance, and accordingly expect serious terminations. This of itself may serve as a cause for the large mortality in these diseases, as the patients themselves, understanding the common expectation regarding them, are liable to “give up” from the start, and so allow the disease to have its full sway without the valuable aid of the patient’s nerve force exercised in the line of recovery. The literature of the eruptive diseases complicating pregnancy is very meager, many writers on obstetrics not mentioning them. All authors write as to the direful results to be expected, as the eruptive diseases are much more dangerous to pregnant women than to other individuals. The condition of pregnancy renders the patient peculiarly liable to the rapid development of infective germs.

The body of the pregnant woman presents that condition of plethora and hyperæmia in the viscera that invites the growth of bacteria. This being the case, it is not difficult to understand why these complications of pregnancy are among the most severe.

\* Read before the Hannemann Medical Association of Iowa, at Council Bluffs.

According to Leavitt the eruptive diseases are more liable to attack pregnant women in the early part of the term.

Variola, the first of those we will consider, is regarded as the most frequent and dangerous of all the eruptive diseases, nearly always proving fatal to mother and child. Fortunately in these days, but few of us ever see this dreaded disease.

Scarlatina is a serious complication, and its virulence is shown from its immediate effect upon the fetus *in utero*. It is very rare in occurrence. Cazeaux never saw a case of scarlatina in pregnant women, but he records the loss of two cases where it followed delivery. We have never seen a case, and know of but one following labor, which speedily proved fatal to the mother. A striking peculiarity of scarlatina observed by all writers is its long period of incubation in the pregnant state. A woman may be exposed to its influence in the early months, only to become its prey during the puerperal state. Miscarriage always takes place, and in the larger number of cases death ensues. Measles, according to Cadeaux and Leavitt, is as grave in effect as scarlatina. Leavitt says it is of unfrequent occurrence, and manifests a strong tendency to become hemorrhagic, and cause the death of mother and child. Pneumonia is a frequent and dangerous complication; abortion nearly always takes place. The mortality from this disease is high: two in eleven cases according to Gautier. Attacks in the early months are not so dangerous as those occurring later.

During the present epidemic of measles in this city, we have seen one case complicating pregnancy at the fifth month. The patient aborted the third day, the case going into complete recovery with no unusual symptoms.

*Erysipelas*.—Leavitt says that it is rare as a complication of pregnancy; is more inclined to attack the face. Its course is not materially altered by the woman's condition, save the added complication of abortion, which is prone to

occur, thereby increasing the gravity of the prognosis. The fatality is about that of measles.

According to a writer in the "American Text-Book of Obstetrics," "Erysipelas is grave or slight as a complication, in accordance as it is accompanied with other forms of septic germs." Facial erysipelas may occur in the pregnant patient, and even abortion may follow, without the development of puerperal sepsis.

Erysipelas of the genital tract or of the lower extremities almost invariably ends in septic infection. According to the sum total of the authorities we are enabled to find upon this disorder, it is considered by physicians of all schools as something to be dreaded, and when it does attack a pregnant patient, as a rule, her doom is sealed.

A case occurring under our observation this past winter well illustrates the foregoing. Mrs. B., aged thirty-three, eight months advanced in her third pregnancy, went riding with her husband on Sunday. The weather was cold, and she neglected to take extra wraps, and became chilled. Nothing was thought of this until the following Friday, when her ears began to swell and burn and pain. She supposed she had frosted her ears while out riding, and applied the usual domestic remedies.

On Monday I was consulted by the husband, Mr. B. and asked to send medicine. Recognizing from his description that the case was one of erysipelas, I insisted upon visiting the patient at her home, three miles distant. Found a well-developed case—both ears enormously swollen and a small area of swelling in front of the ears on the cheeks. On Tuesday morning found no extension of infected area, but the pulse was 120, temperature 104°. The mind was clear, and patient hopeful. At 8.30 P. M. was notified by telephone that patient had given birth to a daughter, labor coming on suddenly and without warning, there being but two pains. On reaching bedside twenty minutes later, delivered the placenta, and assisted patient to bed. Her labor came on while in her reclining chair.

Fearful of results, I remained all night with the case. Immediately after the birth of the child, all the symptoms became intensified. The pulse went up to 150, temperature to 105°. The swelling rapidly extended, traveling across the cheek and closing the right eye, under the chin, and up the left cheek and over the head. At midnight counsel was called, and again the next morning (Wednesday). Pulse and temperature remained at a high pitch, the face and head swelled to an enormous size, pus formed everywhere, and oozed from the eyes and ears, delirium ensued, and death ended the scene Thursday noon.

The testimony of the consulting physicians, one of forty and the other of twenty-five years' experience, was "that they never before saw anything so virulent." The ordinary remedies had no effect. The infant survives, but does not thrive up to this time, although nearly four months have elapsed since its birth.

Much is said in the different text-books regarding the similarity of the erysipelatous infection to that of puerperal sepsis. To illustrate: Mrs. A., aged twenty, under the care of my colleague, Dr. R., came to her full term in robust health; was delivered safely and easily; was nursed by her mother, who came from a neighboring city, arriving the day prior to her daughter's confinement. The mother complained of a sore face, of which but little notice was taken, but which later rapidly developed into phlegmonous erysipelas. At the end of the second day the daughter was seized with severe chills, puerperal sepsis rapidly developed, and death claimed a victim three days later.

These cases and diseases have awaked within me a desire for more knowledge, and a better understanding of them, that we may more successfully combat their baneful influence.

In the ordinary treatment of erysipelas we find the homeopathically indicated remedies all that can be desired, relieving quickly and promptly. In the cases referred to in this paper, I could see no effect whatever.

## NECESSITY FOR DISCRIMINATING DIAGNOSIS IS GYNECOLOGY.

BY L. Q. SPAULDING, M. D.

**T**HE conditions and limitations peculiar to country practice naturally lead me to approach the present subject from the viewpoint of the rural practitioner and not from that of the metropolitan specialist. The proposition embodied in the title of this paper, being of itself practically axiomatic, it needs only to enforce its dictum as cogently as I may, in order that those heretofore inclined to careless haste (if such there are) may resolve upon the attainment of greater diagnostic acumen; while those already careful and thorough may at least feel the comforting assurance that by such measures only are frequent and vexatious blunders to be avoided. My topic may best be illustrated by the citation of a few cases which, while they argue no peculiar diagnostic skill, may be made use of to show the result of careful thoroughness in comparison with more or less decided carelessness.

**CASE I.**—Mrs. D., aged fifty-one, sent for me August 22, 1895. The patient gave a history of illness, extending over a period of a year or more, but never of a violent nature. Her former medical attendant, who had seen her frequently during that time, had given a somewhat indefinite diagnosis of "derangement of the liver," according to the statement of the patient and family. In the many months of his connection with the case, he had never undertaken or suggested a thorough examination, but had contented himself with asking a few questions, taking the pulse, and looking at the patient's tongue. The subjective symptoms were such as to indicate something decidedly wrong in the uterine region; while the general appearance of the patient, together with a well-marked ascitic development, suggested malignancy. Bimanual

examination showed extensive deposit of tumor growths in the uterine and ovarian region, giving the characteristic fibroid feel. The uterus itself was firmly fixed quite low down. No definite lesion of heart, liver, or kidney could be made out. I accordingly gave a diagnosis of multiple fibroid, probably undergoing malignant degeneration. September 17 I removed by aspiration twenty-two pounds of ascitic fluid. My diagnosis of the case was fully confirmed by consultation on the 21st, and by operative incision, which was undertaken by Dr. Gilchrist, on the 25th. The site of both ovaries was occupied by fibroids about as large as eggs, and fibroids of larger size, showing unmistakable signs of malignant degeneration, were found in the broad ligament. The uterus itself was so firmly fixed to the pelvis posteriorly that the operator was obliged to desist. The patient never fairly reacted, and died two days later. No autopsy was held.

CASE II.—Mrs. H., aged thirty-five, sprang from a carriage during a runaway accident some time in January, 1896, the sacral region a little toward the right side first coming in contact with the frozen ground. There was considerable local soreness, but the patient was confined to her bed for a few days only. A degree of stiffness and lameness at and near the site of the injury persisted during the spring and summer, after which the patient seemed in her usual health, or nearly so. December 16, she presented herself, complaining of severe pain of a beating, throbbing character in the locality where the original injury had occurred. Other symptoms were nervousness, sleeplessness, sudden transitory blindness, and frontal headache. She unconsciously held the lower spinal region very stiffly in moving about, and especially in stooping. At one time there were chilly spells, followed by increased temperature, and ending with sweating. Examination per rectum discovered decided tumefaction, and I fully expected a sacral abscess would result. For the purposes of this paper it is not needful

that I should detail the treatment pursued for her relief, but will simply say that in a short time the more threatening symptoms subsided and no abscess formation took place. After the local manifestation had almost entirely ceased, some of the unpleasant nervous symptoms still persisted, and the patient, although nearly free from pain, felt quite bad and was much discouraged. This, together with the knowledge that her general health had been somewhat impaired since the birth of her second and last child in 1892, led me to insist upon a thorough vaginal and bimanual examination of the uterine region. Such an examination the patient had previously refused to allow, but this time the desired permission was granted. A moderate degree of cervical laceration with erosion and endocervicitis was found. Under local and general treatment marked improvement in all previously persistent symptoms has been observed ; still it is my present belief that a satisfactory cure will not be had without trachelorrhaphy. Although this case has not yet progressed to a termination, enough facts have been given to show that a complete and reliable diagnosis could only be made out by a thorough exploration of the whole pelvic region.

CASE III.—Mrs. O., a grass widow, thirty-five years of age, was married fifteen years ago, but has lived apart from her husband for the past thirteen years, earning her own living by doing general housework. Has never been pregnant. Had always enjoyed good health until last October when she stumbled and fell downstairs, causing severe contusion of the sacral region. About three weeks later she consulted a physician, who treated her throughout the winter. During this time she gradually grew worse, and became very much discouraged. No local examination was made by her medical adviser. April 5 she called at my office. Her symptoms were chiefly such as point to uterine deviations and congestions. No practitioner, conversant with such cases, would have suspected external violence,

had it not been stated as part of the history of the case. Right lateroversion with cervical congestion was made out. Appropriate local and internal treatment yielded prompt results, and the patient is again engaged in active household duties, and already declares herself almost entirely cured. I am quite unable to say whether the uterine deviation was caused by the fall or had existed before.

A few words of advice may not be inappropriate here. Never consider the diagnosis of a case absolutely made out, simply because it is sufficient to account for the symptoms present, or because it corresponds with the history given. This applies especially to our professional dealings with women at all times throughout the child-bearing period. Not all symptoms such as suggest uterine reflexes, will be found to depend upon such causes, but it is assuredly better to search occasionally for such conditions, and fail to find them than to frequently fail to search for them when present. In any event, it is safe to say that he who is most careful and thorough in diagnostic methods will have occasion to regret the fewest blunders.





## THE RELATION OF PHYSICIAN AND OBSTETRIC NURSE.

BY HARLAN POMEROY, M. D.

**T**HE relation of the physician and the obstetric nurse has not been very clearly appreciated and not generally recognized. Certainly this matter has not been given the consideration its importance demands, either in current literature or works on nursing. It will be well not only for the physician and nurse, but for patient and community as well, when this relation is properly comprehended. The subject of advanced medical education in its broadest sense is daily becoming of more practical interest and importance. During the past generation, especially within the past twenty years, the advancement along the lines of medicine, surgery, and obstetrics has been very great. Among the many valuable results of this marked advance, one of the most important is the advent of the trained nurse. The vocation of the trained nurse is a comparatively recent one. Especially since the recent effectual efforts adopted, more particularly in the larger cities, to elevate and improve the science and art of nursing, as demonstrated by the rapid multiplication of training schools for its study and practice, has it come to be felt that the nurse is in reality the assistant of the physician during his visit, and his deputy during the physician's absence. In no case has this statement more force than in that of an obstetrician. It is more frequently in obstetrics than in general medicine or surgery that the nurse is called upon to assume, in his absence, the duties properly appertaining to the physician. The nurse may be obliged to deliver the child and placenta, and to see that proper uterine contraction is secured before the physician arrives. For this reason particularly should the nurse be entirely familiar with the conduct of normal labor, for the lives of both mother and child

may depend upon the skill and expedition with which the nurse does her work. Her responsibilities are often great, and require a thorough knowledge on her part of the conditions necessary for her to meet. As in all other powerful reforming agents, the scope of education required is constantly increasing. The requirements demanded of a professional nurse have been gradually enlarged in keeping step with the march of progress, until to-day the elevating and helpful influence of the increased educational advantages enjoyed by the pupil-nurses reacts and permeates the entire medical profession. Not only is the profession of nursing elevated, and kept on a higher plane, but the confidence of the physician or surgeon in his ability to successfully manage what would ordinarily be considered desperate cases is vastly increased, because he has confidence in his trained help. Florence Nightingale, with her ten years of preparatory hospital training, is the type of the trained nurse, just as Sairey Gamp, with her ignorance and drinking proclivities, is an example of the untrained. Such an innovation as the substitution of a trained nurse in the place of the untrained, inefficient, and often far from aseptic help formerly furnished to assist the physician requires time. People will not accept a new idea, no matter how reasonable it may be, in a day or a year; perhaps not in a century. While less important changes have required considerable time, perhaps generations for their accomplishment, Florence Nightingale, the originator of training schools for nurses, is still living in her English home. This circumstance will emphasize the fact and assist one to appreciate the rapidity with which this reform has extended. The enterprise of establishing training schools is rapidly extending, particularly in the larger cities; indeed, there are now over two hundred training schools in this country, with upward of four thousand students, and more than fifteen hundred graduates. This rapid increase in the number of training schools demon-

strates the facts that the services of a trained nurse are coming to be more thoroughly appreciated. One of the foremost causes of this increased call for trained nurses is the recent advance made in the medical, obstetrical, and surgical practice, which requires greater care and closer observation of the sick than untrained nurse are capable of giving.

It is for the purpose of supplying these requirements that the so-called training schools for nurses have been established. It has been truly stated that "nurses are made, not born." However, it is equally true that "natural aptitude" for nursing must be supplemented by proper and thorough training. The overanxious family and friends are often the poorest attendants the patient can have in a serious illness. The necessity for proper assistance in caring for the sick has been recognized for many years by some physicians, as the following quotation will prove. Dr. Smellie of London, in his "Treatise on the Theory and Practice of Midwifery," published in 1752, says of nurses in general: "Nurses as well as midwives ought to be of middle age, sober, patient, and discreet, able to bear fatigue and watching, free from external deformity, cutaneous eruptions, and inward complaints that may be troublesome or infectious. Nurses that attend lying-in women ought to have provided, and in order, everything that may be necessary for the women, accoucheur, midwife, and child.

"After the delivery the nurse's business should be to attend the mother and child with the utmost care, and follow the directions given her regarding the management of each."

As professional people we should recognize this as healthy sentiment.

We must, as obstetricians, do all that lies in our power to assist the parturient woman. While women, more particularly by their special adaptation by sex, nature, moral perceptions, and endowments, being patient, gentle, and

sympathetic, are particularly suited to the office of nurse or assistant to the physician in obstetric practice, yet even with the constantly and rapidly increasing supply of trained nurses, a successful and thoroughly competent care-taker of the sick is rare unless the person possesses a natural aptitude for her work. There are certain mental and moral, as well as physical and politic traits that a woman must possess, or else she will fail to make a success of her undertaking. Many otherwise faithful and efficient women are absolutely unfit to nurse a patient simply from lack of those traits essential to a properly balanced educated nurse. Preventive treatment is of infinitely more importance, especially in obstetric practice, than is curative, and it is in this relation that the well-trained and conscientious nurse is so valuable, for she realizes that inattention as to cleanliness endangers the patient's life; hence that carelessness would be criminal.

One writer says: "A valuable adjunct to the obstetrician as well as the prospective mother is a trained nurse. The fact that educated, skilled nurses, who are reticent, dignified, and obey orders explicitly, are being educated, and introduced to the homes, is the subject for congratulation. The value of such a nurse is more thoroughly appreciated since so much stress is laid on antisepsis and asepsis in the puerperal state. Antisepsis is progressing and developing into the higher and more practical condition of asepsis."

It has been truly said that success in obstetrics consists in the most careful attention to minute details. While it may be possible for the physician to leave the details to the nurse, he must be assured that the nurse is thoroughly competent. If the nurse be a stranger to the physician, he must investigate all the details of her work, and watch carefully until convinced that she will do the work according to his ideas. Many times disappointment follows the employment of a so-called trained nurse, because too much is expected of her. Simply because a woman has been

through a training school, it does not follow that she knows all there is to be known about nursing. It would be just as fair to conclude that a person who had recently graduated from a medical college knew all there is to be known about the practice of medicine. The training in both cases is preparatory for the work to follow, and furnishes a sure foundation for further learning. One of the chief objects of the training school is to assist the pupil nurses to become intelligent, moral, self-supporting assistants to the physician and surgeon. In doing this any undesirable tendencies—physical or mental—should be eradicated or modified. Teachers in the training schools should make an effort to instruct the pupil nurses, not only as to the most important things for them to attend to, but also as to certain important things to be avoided by them, such, for instance, as the prescribing of remedies. There is an important question as to how much materia medica the nurse should be taught. If the pupil nurse desires to become a physician, that is her privilege; but she should study medicine in the ordinary manner and thoroughly qualify herself. Many nurses make mistakes in this direction. The profession of nursing is dependent upon the medical profession, and it is a mistake for a nurse to usurp the physician's particular privilege. It should be insisted upon that the medical attendant alone give instruction regarding the management of each particular case; then it becomes the duty of the nurse to faithfully carry out the physician's directions, and to report to him at each visit the effect of the treatment. The physician and nurse expect, and should have,—*must* have, if the results of their combined efforts are to be crowned with the highest degree of success,—the earnest support and co-operation of the patient, that everything may work in harmony with those who are working for the patient's welfare.

Briefly indicated, the requirements now demanded of the pupil nurses in the Cleveland Training School

for nurses are as follows : First, a comprehensive knowledge of the anatomy, organs, and tissues concerned in parturition ; and also the physiology of gestation, including the symptoms indicating pregnancy. The hygienic requirements of the gestative period must be understood, as must also the symptoms indicating the approach of labor, such as the sinking of the uterine tumor a few days prior to labor, the bloody mucous discharge, regularly recurring pains, and cervical dilatation as labor commences ; also the circumstances attending the three stages of labor. As to the duties developing upon the nurse in an obstetric case, while physicians differ as to details, the following points are insisted upon as essential : First, the nurse should go to her patient promptly when the call comes, that she may have ample time to prepare the prospective mother for the coming event, and be prepared for any emergency. She should go in an aseptic (clean) condition. Chemical sterilization and mechanical cleanliness as to clothing and the paraphernalia are deemed valuable acquirements in the nurse. The nurse should never go from a suspicious puerperal condition, or any septic or contagious trouble, to an obstetrical case, for the lining of the puerperal uterus is eminently adapted to the reception and development of germs. Upon the nurse will devolve frequently the duty of informing the prospective mother regarding the provisions necessary on her part, therefore, the nurse is urged to familiarize herself with the essentials. Of course the details may be modified and amplified indefinitely. At the inception of labor the nurse is instructed, after having washed her own hands in alcohol, to give a rectal injection, and to see that the patient's bladder is emptied ; to give the patient an antiseptic vaginal douche with creoline emulsion, one dram to the quart ; or mercury solution, regulating the strength according to the conditions existing ; it may be from one to six thousand to one to one thousand, after which a vulvar pad saturated with creoline emulsion is kept over the vulva.

Asepsis is the rule with reference to anything coming in contact with the patient, such as the clothing of the person and bed, vulvar pads, etc. Following labor the record kept by the nurse should be accurate in regard to the patient's nourishment; she should note her general appearance, amount of sleep, character of after-pains, any chill or complaint of chilliness, rise of temperature, frequency of pulse, character of lochial discharge, urine, and dejections.

After the first week a more simple record will suffice, providing no pathological conditions exists. Rest for the patient must be secured immediately after labor, the nurse watching carefully, especially after the first sleep, with the general relaxation which it induces, for any indication of hemorrhage; especial care should be observed to guard against depressing mental or nervous influences. As soon as the patient is made comfortable after delivery, she may be given a cup of warm milk. A light diet, consisting of milk toast, some cereal, or a limited allowance of animal broth, cocoa or chocolate, may be given for a day or two, limiting the amount of liquids if the breasts threaten trouble. After lactation is established and the bowels are thoroughly opened, the normal diet may be resumed. Tender beef, mutton, chicken or game, soft boiled eggs, baked apples, potatoes, simple desserts such as custards, blanc mange, and wine jelly, avoiding sour fruits, fancy and highly seasoned food, desserts, and stimulants. At the end of ten days the regular meals may be given, consisting of a plentiful and nutritious menu, but selected carefully with reference to its digestibility, modifying the diet of course as special indications arise.

The training which the nurse secures at the training school may and should very naturally make her quick to acquire the methods of the physician, so that one will adapt herself to the requirements of the attending physician and necessities of the patient. The true relation of the physician who is responsible for the case, and the nurse whose

duty lies in faithfully carrying out the physician's scientific methods of treatment, is implied when they are considered as the obstetrician and assistant.

Our friends of the legal fraternity sometimes "suggest a death" to the court, when the knowledge of the fact is necessary to the successful conduct of the case. I would like to suggest a birth, the birth of the profession of the trained nurse, believing it to be essential that the existence and influence of this new profession should be appreciated by the medical profession. In my judgment, it would be wise to devote time in future meetings of the Institute to the consideration and discussion of the interests pertaining to the training schools for nurses.

## THE LIMITATIONS OF THERAPEUTICS IN THE TREATMENT OF GYNECOLOGICAL DISEASES.\*

BY JAMES C. WOOD, M. D.

[T must be confessed, that the good old doctor of forty years ago had, in a good many instances, a very profound knowledge of many things; and that he considered himself capable of dealing with all the diseases enumerated in the nosological catalogue. To him the unity of the organism was a self-evident fact not to be questioned. Experimentally he had learned that there exists no organ in the human economy which is independent of its fellow or fellows. This knowledge kept him from committing the sins with which some of the specialists are charged. Sims and Simpson, McDowell and Batrey, and many others could not have accomplished what they did, had they not builded upon a superstructure of this varied experience. This is an age of specialism. Medicine has been divided and subdivided

\* Condensed abstract of a paper presented to the American Institute of Homeopathy, 1897.



until a point has been reached where little is left the general practitioner except the eruptive diseases; and prophylaxis and serum therapy are in a fair way to annihilate these affections.

True specialism is but a consummation of much that is below it. All of the departments have been given such an impetus by the splitting process, that I cannot conceive of anyone desiring to return to the old order of things. There is in gynecology a greater opportunity for abuse than in almost any other department. When young men and women walk deliberately and directly into it before the ink is dry on their diplomas, with no knowledge of general medicine, the true order of things is reversed: the specialty masters the man and not the man the specialty. Indeed, in any specialty the natural bias is to find ætiological factors in the specialty organs whose diseases have been the especial study of the examiner.

I am firmly convinced that many women have been operated upon who might have been cured by proper internal and local medication. But I am equally conscious that even more harm has been done by those men whose faith in therapeutics leads them to rely exclusively upon a blind symptomatology and internal medication long after the disease has become surgical. It is certain, however, that in dealing with the question before us we cannot be governed by gross pathological changes alone.

Four weeks ago I operated upon a woman who had become incapacitated for all work by a severe pain in the right side. She had been under the care of excellent therapeutists. Section disclosed left ovary buried in a mass of inflammatory exudates the size of an orange. Complained of no distress in left side. Opening right side found outer half of ovary in cirrhotic degeneration, a condition which could not be detected on bimanual examination, but which squeezed terminal fibers in such a way as to cause both local and general disturbance. And so with

other lesions. Once I removed, *post-mortem*, from a woman ætat seventy-five a calcareously degenerated fibroid as large as a fetal head, which had so effectually occluded the right ureter as to have caused complete destruction of the corresponding kidney, and yet the patient had not complained either of uterine or kidney trouble.

The power of drugs to favorably influence certain diseases must necessarily depend upon other factors than mere tissue changes. The impressionability of the patient, her environments, her social status, and her habits of life must be well weighed. We know that certain organisms are more susceptible to drug action than are others. Other than accidental lesions, nearly all of the diseases of the pelvic organs are functional before becoming organic.

What is cancer? Is it of embryonic origin, or parasitic, or are the two theories compatible? The fact remains that the victim is not born with cancer, and indeed recent statistics show that heredity plays a much less important rôle in its production than was formerly believed. I think it can be summed up in the one sentence: "Diminished physiological resistance."

How often do we meet with cancer of the breast or of the uterus in women who have recently undergone profound mental shock or depression? The disease localizes itself in that part of the body which furnishes the most fertile soil for its production. Cancer is essentially an organic disease, and up to the present time it cannot be said that any degree of success has been met with in its treatment by internal medication. If we admit that it is due to diminished physiological resistance, the conclusion is that the disturbance of the system which precedes the death of tissue is purely functional; and that if the system is put to rights by a properly selected remedy, and other necessary treatment, no cancer will occur. Cancer, and especially of the uterus, is largely a preventable disease. By correcting local lesions, and particularly lacerations of the uterus, and

by keeping the general nutrition at par, the annually large number of deaths from this cause may be diminished.

That the homeopathic remedy is of inestimable value in dealing with the precursory symptoms of cancer is unquestioned. Up to the present time there is not to be found one single authentic case of cure by internal medication alone.

Two months ago a woman of thirty-eight, who had been bleeding almost continuously for twelve weeks, consulted me. Discharge offensive, skin dirty straw color. Examination found the uterus enlarged, cervix lacerated, everted, indurated, and cervical mucous membrane abraded. Being confident of the existence of a malignant condition, I curetted, and had the curetted tissue examined by a pathologist, who reported a fungoid endometritis with cystic degeneration and erosion of the cervix. A week later, while operating, I felt that his diagnosis must be in error, and was tempted to remove the uterus. Instead, I worked along conservative lines. The patient convalesced, and the cervix to-day is perfectly healthy. From this may be seen how valueless are the recorded cures of cancer where the diagnosis is unconfirmed by microscopic examination. And what is true of cancer is true of many other diseases. Personally I have not the slightest faith in the reported cures of ovarian cysts by internal medication.

Professor Ludlam has collated the record of a series of ovarian tumors, in the second volume of "Arndt's System of Medicine," alleged to have been cured by internal remedies. There is not a single case in the series which carries with it conviction.

No member of the bureau will dispute the efficacy of homeopathy in dealing with these conditions of the ovary—congestion, irritation and inflammation—which are responsible for adventitious growths of that organ. Possibly as our art advances to a higher degree of perfection we may be able to cure ovarian cysts without the knife.

Dr. Burnett in his "Organ Diseases of Women" gives a number of alleged cures of various organic diseases of the pelvic organs by medicine alone. While it is not my purpose to raise the question of potency, one is impressed in reading his book that he usually begins his treatment with the CC potency and ends with several drops of the mother tincture. The author clinches his claim by the following "profound" observation: "The manifold operations on women are, for the most part, absolutely useless, often harmful, and not seldom fatal. How can one cure the quality of a patient by cutting a piece off her?"

The gynecologists are pretty much all on one side in this question. While none of us deny the wisdom of combining general with local measures, few of us have that sublime faith in homeopathy to believe that the indicated remedy alone is sufficient for the cure of the lesions enumerated. The pelvic neuroses on the other hand afford abundant opportunity for a wide range of opinion. More disappointments have followed operations for the relief of nervous symptoms than of any other class of affection. I believe firmly that clear and definite evidence should be had connecting the neuroses with the sexual function before an operation is justifiable. Without such evidence no man has a right to subject his patient to a critical operation before all conservative resources, including medication by a "therapeutic specialist" have been exhausted. I use the term advisedly, for if we as gynecologists insist that cases shall be turned over to us before the local affection has so far advanced as to prejudice the outcome, it is no more than right for us to give the patient, where operative interference is not imperative, the benefit of remedies selected by men who stand head and shoulders above us in their knowledge of drug action. But we are confronted with the fact (one case of which has already been shown in this paper) that the most expert diagnostician may be unable to detect an ovarian lesion before the abdominal section and without the use of

the microscope. A point may be reached in descending the pathological scale where, instead of actual disease, simple functional disturbance calls for operative interference in order to abrogate a bodily function whose performance precipitates the neurosis in hand. In such neurotic diseases we have doubtlessly operated with unnecessary frequency.

Perhaps we are not obtaining the best possible results from our homeopathic remedies by the present method of administration. Dr. Coley's experiments with the toxins of erysipelas and prodigiosis [?] are certainly worthy of consideration. The question is: Might we not be able to accomplish more with the indicated remedy, were it injected directly into the tissue in which the disease is localized? I am aware that this has been done with a few remedies; but we have the whole range of our *materia medica* to draw from. Were it possible for our pharmacists to furnish us with a complete set of remedies, non-alcoholic and sterile, to be selected strictly in accordance with the homeopathic law, and applied directly to the seat of the disease, when possible, it is not unreasonable to believe that even cancer may in time become a curable disease without the aid of the knife.

#### DISCUSSION.

DR. W. A. DEWEY.—I am compelled to admit that no hard and fast line can be drawn between the diseases amenable to internal medication and those which are not. That covers the question in a nutshell. That homeopathic therapeutics have saved many a patient from the necessity of the surgeon's knife is incontestable. The paper covers a large and comprehensive field. In the first place, it covers the field as to the curability of uterine cancer. There must be in every case of cancer a time when the homeopathic remedy will either cure or prevent further development. In any case, there must come a time when the knife will not cure. Without these hard and fast lines, how are we to tell when the function of the therapist ceases and where the knife comes into play. A doubt has been expressed whether

cancer has ever been cured by the homeopathic remedy ; I believe there are a number of authenticated cases on record, and I would cite the case of Field-Marshal Radetzky cured by carbo. veg. and thuja. There are other cases which might be mentioned where the best diagnostic talent of the day was called in, and I believe the question is an open one. Personally, I think cancer has been cured by the internal homeopathic remedy. We are about to lose sight of the fact that the prescription should be not upon the diagnosis, but upon the symptoms presented.

I would say that about two months ago I read in the *Medical Record* in reference "Erysipelas" Antitoxins and their Effect upon the Malignant Growths, the following, "One by one our fondest hopes decay." So it would seem that even the old school had about given it up. There is a question whether we get the full and best effect of the remedy by administration per oram, or would it have a stronger action if injected into the tissues ? This is an important question, and would lead up to the proving of remedies upon the healthy by the injection method.

DR. R. C. ALLEN.—We are frequently called upon to treat cases which have been given up as hopeless by the surgeon, and in many cases have cured them. I had a case six or seven years ago in which there was made a diagnosis of uterine fibroid. Dr. Van Lennep confirmed this diagnosis, and offered no relief surgically, believing that the patient would surely die before long. Her friends expected her death, but by the aid of the internal remedy she is to-day a well woman, and a fine specimen of physical womanhood. The remedy was thuja.

DR. J. M. LEE.—I will report a case of cancer of the cervix uteri which was brought to me, and in which I could offer no surgical relief which promised success, but which was cured without operative measures. The patient was taken by her physician to a surgeon of undoubted skill and great experience and candor, who diagnosed it as a case of cancer, but refused to operate, as it had gone too far. Her physician then took her to a pathologist, who removed a piece of the growth and submitted it to a microscopical examination, and pronounced it cancer. Her physician then tried an experiment which he had had under consideration for some time—he was an old-school man. I am unable to give you

the names of all the ingredients of the mixture he used, but there was nothing given internally. As I recollect it, he took a piece of asbestos and wound it on a stick. After placing the patient in a strong light and introducing a speculum, he poured into a saucer some turpentine, iodine and, I think, bromine ; when the last substance was introduced there was an explosion followed by a flame. The asbestos was dipped into the burning fluid, and, while the fluid was sticking to it, was placed against the cancerous tissue. This was done twice a week. At the end of six months I examined her at his request, and found no granulations, no ulceration, and no signs of cancer, but a smooth, yielding cicatrix covering the whole surface, and the woman was apparently well. I recall another case presenting all the symptoms of cancer, but which was not examined microscopically, cured by kreasotum internally and a vaginal douche of carbolic acid.

DR. T. GRISWOLD COMSTOCK.—I never saw a case of cancer cured by remedies. I had a patient, about passing the climacteric, who had a fibroid. I advised operation, but the advice was not followed. I sent her to Chicago to see Dr. Ludlam, but she went to Dr. Martin instead, and he advised removal. She then went to Dr. McClelland of Pittsburgh, who, I believe, did not advise immediate removal. Betts of Philadelphia and Price of the same place advised removal. Cushing of New York proposed to remove it by dieting the patient. Finally she came back to St. Louis, fell into the hands of a massage doctor, and is doing well.

DR. J. J. THOMPSON.—It seems curious that after so many well-authenticated cases are brought to light still there are learned men who say that cancer cannot be cured by the internal remedies. I have now under my care a lady who some eight years ago had her disease diagnosed by Professor Hobart of Chicago as cancer of the uterus. He called Dr. Charles Adams, of the same place, in consultation, who pronounced it cancer and advised operation, without, however, holding out a very substantial hope of cure, so the advice was not followed. She was then put on the opium treatment to relieve pain, and at the time of Dr. Hobart's death was taking an immense quantity of opium daily. To-day she is not taking any opium, seldom complains

of pain, and eight years after the first diagnosis of cancer there is very little enlargement of the uterus. She was under Dr. Obetz for three years, and he gave her arsenicum. Since then I have occasionally given her the same remedy in the 3d to the 30th potency. She is well, and presents no symptoms of cancer. I believe there are many here to-day who could tell of similar cases. Those who use the knife, and like to use it pretty well, are apt to want to use it in all cases. If the materia medica men would report their cases of this kind, as do the surgeons, we should have in course of a few years a valuable lot of statistics.

DR. G. F. SHEARS.—If we accept the cause of cancer as laid down, and I am inclined so to do, there are two elements to be considered: first, an inability to combat disease and, second, a source of infection of some kind. Consequently there are two elements to be met: First, the removal of the morbid product, the infected tissue; and, second, to overcome the weakness of the organism. In the treatment of these cases I strive to meet both conditions. First, I remove all that will effect or infect surrounding tissue, but I do not stop there. I think we stop too soon—we do only one-half of the work when we simply remove the infected tissue but fail to remove the inherent tendency or to build up the patient. If we will be both physician and surgeon the possibility of curing cancer will be much improved. I believe it has been cured by remedies—at least there seem to be cases of record; but I believe a larger number will be cured by a judicious combination of both measures, as suggested. I believe the homeopathic remedy will do its best work here. It is unfair to blame the remedy when the infecting condition is allowed to remain. This does not give the remedy a chance. Be both physicians and surgeons in the treatment of uterine cancer.

DR. J. C. WOOD.—I am occasionally mistaken in diagnosis. I cannot tell sometimes until I explore it, what there is in the abdominal cavity and I cannot diagnose a cancer except by the aid of the microscope. If there is any way we can find out to a reasonable certainty, that cancer can be cured by internal medication or local application, that is what I seek to know. The doctor who reported the cancer cured by thuja did not take into consideration the fallibility of human nature. I saw a case given



up by five surgeons; the patient was practically dead, as far as could be told. We left her to die, but she got well instead, and that with out any internal medication.

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### SOME OF THE COMPENSATIONS FOR THE OPERATIVE CRAZE IN GYNECOLOGY.\*

BY R. LUDLAM, M. D., CHICAGO.

DR. LUDLAM, after speaking of the undoubted harm that has been done to gynecology by the indiscriminate doing of operations by many inexperienced operators, and in a general way condemning the craze of doing gynecological operations, says that nevertheless he thinks it possible to show that it has really been a blessing in disguise; for like most of our resources, it may be useful and precious in proportion as it is harmful when misapplied. This ignorance, says Dr. Ludlam, is due, first to ignorance of pelvic and abdominal pathology; second, the great number and the peculiar suffering of the class of patients that were interested in this specialty; and third, hasty and inadequate preparation for a professional emergency.

When the Institute held its last session in Buffalo (1855), its entire membership knew little or nothing of the special pathology of the diseases of women; and the same was true of physicians everywhere. In 1865, when Dr. Ludlam at Cincinnati proposed the formation of a Bureau of Gynecology, very little thought was given to the suggestion. In 1873 finally a sub-bureau was established. Until the late Dr. Ormes of Jamestown, N. Y., brought a patient before us at the Chatauqua meeting in 1877, not one in a thousand of us had ever seen a live woman from whom the

\* A condensed abstract of a paper read at the American Institute of Homeopathy, Buffalo, 1897.

womb and appendages had been successfully taken. Porro of Pavia had done his first hysterectomy in 1876; Rein of St. Petersburg practiced excision of the gravid uterus without hemorrhage in 1878; and Storer of Boston had already removed a tumor without knowing that the imbedded womb contained a fetus.

In the intervening twenty years naturally enough the dash and flash of a great number of surgical exploits has unbalanced the professional judgment, and evolved a swarm of pseudo-surgeons, who think more of new expedients and a brilliant and skillful technique than of sound principles and the best ultimate results.

At the renaissance of gynecology it had more material at hand in its outset than any of our specialties. This abundant supply of material so increased the demand for gynecological specialists that half the doctors went crazy forthwith. And nothing would bring them into notice more quickly and surely than a bit of audacious surgery practiced upon somebody's wife or sister.

At the breaking out of the Civil War there was a host of half-starved doctors and unripe graduates from all over the country who suddenly became patriotic, and as suddenly were possessed of the idea that they must enter the army as surgeons. The scramble for place was ridiculous. It is almost as difficult, in ordinary times, to tell where the doctor merges into the surgeon, as it is to say where the lamb ends and the mutton begins. But in this case the transition was abrupt and phenomenal. As a consequence, professional emergency maimed and sent thousands of our soldiers to untimely graves.

So with the advent of gynecology. It represented a later issue, and hundreds of physicians of all schools and of no school entered the army of gynecological specialists. They had mustered themselves in, and bad luck to it, nobody had the authority to muster them out.

In this way, says the essayist, may we account for the

sudden large accession of gynecologists. The strife was for the largest number of victims, and very few women were allowed to escape. If this sounds like turning State's evidence, it notes the facts of the case, and concedes the right of those who have not fallen under the sway of the operative craze to publish and defend their views. They are fully justified in exposing the abuses and the excesses of a mode of practice which they could not honestly approve; and in their reaction against it have very naturally gone to the opposite extreme. Out of this manifest abuse there has come some compensation to the profession: First. Increased precision in pelvic and abdominal diagnosis; Second. Greatly improved methods of treatment; and Third. The opportunity for those who are honest to learn the hard lesson of their own limitations.

Prior to the gynecological era it was considered criminal to open the abdominal cavity in the living subject, Cæsarean section alone excepted. As a result, the real lesions could only be determined *post-mortem*. Abdominal section turned the light into the "sacred" cavity that has proved a mine of wealth to the pathologist. What has been skillfully and successfully done through Tait's window is within your general knowledge. That lesson was first taught by gynecologist. Let me illustrate:

In less than a month after this Institute held its thirty-fourth annual session, two of the most distinguished surgeons of this country were confronted with a bullet wound of the intestines in the person of the honored President of the United States. For eleven mortal weeks the slender, shifting expectant method of always keeping out of the abdomen of the living lest one might learn something, or do something more for human relief was practiced. It had the approval of the great majority of physicians and surgeons. Those of us who had repeatedly made the abdominal section for a different purpose were treated each morning with a record of the illustrious

patient's pulse and temperature, and were left with the conviction that he was dying, as he did finally die, of a preventable pyæmia. Dr. Sims, of immortal fame, begged the privilege of opening that abdomen, exposing the wound, and treating it properly. But, no, the surgeons were not practically familiar with that kind of work, and the general profession would not sanction such bold and unheard of procedure. They did, however, permit the stupid use of electricity in order to locate the position of the leaden bullet, which was the only new expedient they were willing to try!

If Spencer Wells had not sacrificed a few worthless dogs to teach us how to join the surfaces (not the edges) of the severed peritoneum, the surgery of all the serous membranes would have been much less perfect than it is to-day. This increased knowledge enables us not only to identify the lesion but also to proceed directly to the relief of those cases which, since there is no time to lose, cannot bear even a vigilant delay. Moreover, if the diagnosis is clear the operative indication will not be foggy nor misleading.

Gynecological surgery has also rid us of certain fads and methods of treatment that were extremely foolish and mischievous. The curette has been revived, and has superseded almost any amount of "topical tinkering," by a clean, safe, and prompt method of relief in suitable cases. The early and radical operation for uterine cancer has added years of bearable and comfortable life to the experience of thousands of women. In general medicine and surgery the abortive treatment of peritonitis and the practical safeguard of asepsis, both of which were first employed by the gynecologists, have done and are doing an inestimable service.

A compensation that should not be forgotten is the reform in the practice of dosing and over-medication. Those who had once drugged their patients excessively

could not be expected to practice gynecological surgery with any better reason or judgment. Nobody does both; and, therefore, what is charged to the scalpel should be credited to those who in going to an opposite extreme have discarded the reckless use of drugs.

In closing, the distinguished essayist said that the reaction against an abuse is wholesome when it quickens the sense of justice to all parties. If the general physician had been less narrow and inelastic in his theories, and the specialist more thorough and conscientious in his practice, the resulting mischief would have been averted. There is no choice between a medical crank and a crazy specialist. It has been said that "if meddling midwifery is bad, meddling gynecology is worse." But gynecology is neither meddling or mischievous when its principles are sound and its practice is in the largest and best sense successful. There can be little doubt that with judgment and experience the profession will finally arrive at a correct estimate of its resources, whether they be medical, surgical, or miscellaneous.

#### DISCUSSION.

DR. T. L. MACDONALD.—Dr. Ludlam disparagingly admits that surgical operations are performed unnecessarily, without sagacity, but with untrustworthy experience. This is too true, and I would add that they are performed frequently without definite surgical indications. Legitimate surgery should have its indications just as a drug has its indications. It has been said that the physicians and surgeons are pulling apart; it is almost impossible—their interests are combined. I frequently tell the family that the restoration of the patient is due as much to the family physician as to the surgeon. If the family physician would familiarize himself with the indications for operative gynecology, it would materially simplify matters. Some time ago Dr. Ludlam said in an editorial: "Let us have surgical indications for the operations done by surgeons; an adoption of this plan would result in less criticism." As a general surgeon I am somewhat unwilling to

concede all that Dr. Ludlam claims for the gynecologist. He mentioned asepsis and the prevention of peritonitis. I do not believe we can have a perfect asepsis without antisepsis.

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### A STUDY IN HYSTERECTOMY.\*

BY W. E. GREEN, M. D., LITTLE ROCK, ARK.

DR. GREEN said in opening that he had given the treatment of cancer by medical means alone nearly fifteen years of trial, but finding no trustworthy results from such treatment, he was glad to adopt the surgical treatment, which, about the conclusion of that period began to be advocated. He had already had some success with surgical measures in cancer of the breast, and was ready to apply the same principles to cancer at other points. Since he had so applied his knowledge, he had had to record but one death from that dread malady. He was, therefore, greatly surprised at the trend of the discussion on this subject at the last meeting of the Institute, when some members claimed the curability of cancer by drug action alone, and gave such faint endorsement to surgical methods. Because of a statement by Dr. Byrne in the *American Journal of Obstetrics*, in October, 1895, to the effect that "if the alarming proportions of rapid recurrences of cancer after vaginal hysterectomy, as heretofore conducted, means anything, it would seem to indicate very conclusively that the results following hysterectomy do not justify the means," the essayist was induced to attempt an investigation through the surgeons of our own school, and, therefore, sent out carefully prepared questions to more than 50 operators in vaginal hysterectomy, and received statistical replies from 23. A careful analysis of these statistics reveals the following facts: total number of hysterectomies

\*Condensed abstract of a paper presented to the American Institute of Homeopathy, Buffalo, 1897.

performed by the 21 operators, 1009 ; primary deaths, 30 ; a mortality of 2.97 per cent. Ten operators who reported each from 3 to 30 inclusive, gave 150 operations with 10 deaths—a mortality of 6.66 per cent. While 10 who performed each more than 30 (32 to 236) reported 859 operations with 19 deaths—a mortality of 2.09 per cent. This would indicate that the death rate diminished with the number of operations performed, or, in other words, experience is a factor of no mean proportion in estimating the mortality of vaginal hysterectomy.

Dr. Green then goes at length into the statistics of the answers sent him, devoting several paragraphs each to the method of operating, the cause of death, injuries, post-operative changes, sterility, obliteration of connubial feeling, changes in physique, vaginal mutilation, co-removal of uterus and appendages and cancer of uterus.

On this latter theme Dr. Green said: I expected an exhaustive report upon this important subject, but with very few exceptions the statistics were vague and incomplete. This was especially noticeable in regard to the recurrence of cancer after removal of the uterus. However, the operators were a unit in regard to the advisability of hysterectomy in cancerous cases. All recommended its application at the earliest possible moment that a correct diagnosis could be made ; in fact, many advised its execution even in suspicious cases, thereby giving the patient the benefit of the doubt. An operable case in cancer of the uterus was in substance in every instance defined to be one in which the organ is freely mobile, and the infiltration not having extended to adjacent structures. The answer to the question "When does cancer of the womb cease to be medical and become a surgical case?" was likewise a unit, in substance as follows: "Immediately upon the diagnosis of the disease." McDonald states that "a case of cancer of the uterus is never medical until after it becomes inoperable."

In reply to the question: "Do you believe that the disease can be cured by the internal administration of any known drug?" every operator answered "No!" without qualification. An equally emphatic "Yes!" was given to the question "Do you speak from personal experience?" The inefficacy of drug treatment of cancer of the uterus is so summarily and positively dealt with by these operators, that the subject may well be dismissed without comment. The propriety of total extirpation of the organ hinges upon the liability of recurrence in operable cases, the abridgment of suffering, and the prolongation of life where adjacent structures have been involved and a return of the disease was expected. In order to arrive at definite conclusions upon either point, we are dependent almost wholly upon clinical research. A study of the literature of uterine cancer leads to the conclusion that the mode of extension of the morbid process depends largely upon the portion of the organ in which the malignancy develops—which is by infiltration and lymphatic dissemination. Secondary involvement is usually through extension to adjacent tissue—the bowel, bladder, vagina, broad ligament, and ovary being involved in the order named.

After following out the course of extension of cancer through the anatomical structure, Dr. Green said that he had performed vaginal hysterectomy for malignant diseases of the uterus upon 13 patients, all of whom had remained more or less under his personal observation: Case No. 1, no recurrence; operated October, 1888. No. 2, operated September, 1890; no recurrence, but suffering with severe pruritus. No. 3, no recurrence. No. 4, no recurrence. No. 5, no recurrence. No. 6, no recurrence; patient weak and debilitated, and has suffered more or less ever since from weak heart with frequent attacks of fainting. No. 7, no recurrence. No. 8, operation August, 1894; recurrence in both broad ligaments, large tumor now developing in both sides; patient before the opera-



tion suffered from severe and constant pain; since the operation and until recently has had but little discomfort and apparently in good health. Nos. 9, 10, and 11, no recurrence. No. 12, operation July, 1896; recurrence in rectum and bladder. Patient lived seven months. No. 13, operation December, 1896; no recurrence; still living, but in feeble health, suffering from pulmonary tuberculosis.

Then follows an exhaustive analysis of 32 hysterectomies performed by Dr. Green, the first in October, 1888, and, to this date, without a primary death. Six of the 32 were complicated with fibroids of variable sizes. All had rectal work done at the same time, where necessary, and 5 had anterior colporrhaphy and perineorrhaphy. The ovaries and tubes also were removed in every instance, except in 5 of the older subjects. The youngest was twenty-two and the oldest sixty-six years. The first operation was done with clamps, the remainder with absorbable ligatures. With the exception of the first, eighth, and the twenty-ninth, the peritoneal and vaginal rents were accurately closed without drainage. In no case did hemorrhage, high temperature, or sepsis occur. All of these patients were confirmed invalids, most of them having undergone treatment at the hands of numerous physicians without relief.

Dr. Green closes his interesting paper with a few pages of "Operative Hints."

#### DISCUSSION.

DR. O. S. RUNNELS.—If I am asked if I am a physician, I say "Yes." If I am asked if I am an homeopath, I say "Yes." If I am asked if I am a surgeon I say "Yes," but, more than all, I claim to be a doctor. No person should ever assume charge of the cases under discussion unless he or she is a doctor in every sense. The field should not be narrowed in any way. There is much to be thought of in the management of these cases, and much which should not be lost sight of. All forms of medical treatment are largely palliative; the prevention of the disease is the greatest charity one can render. It is well to be able to cure,

but if you can prevent invasion you have done much better work. It is a question which gives us as much to think of in way of prophylaxis as does yellow fever, cholera, or any other disease. There is much room for study in how to prevent or to hedge against it, and that should be the object of our work. No man is a surgeon who is not a good physician and who has not spent a large portion of his life in finding out what he can do with drugs. We put the best efforts of our life into this work; we should not narrow it down and endeavor to set up a wall between physicians and surgeons. We are doctors; that is the groundwork of the whole thing. Cancer comes as a result of some irritation. It was not cancer at the start, but something benign, and that is the time for therapeutics and expedients. But there comes a time when it begins to exchange benignancy for malignancy. You have now no time. Draw a cordon of prophylaxis about it, and if you can remove it, do so—it is your duty; no matter what the means, so you accomplish your purpose. We know some do get well under this or that measure, but the surgeons are united in thinking extirpation the best course. Now and then there may be a miraculous cure internally or locally, but it is both unsafe and unscientific. At first, if you will, by trachelorrhaphy, curetting, or any other minor measures, or, in fact, by *any* measures, but get rid of it. Do not allow your patient to have any dust thrown in her eyes. We have made many errors, we have fallen and stumbled, but by so doing we gain dexterity, so we do better this year than last year, and shall do still better next year. I bring to you the result of my own knowledge and experience when I say that the only thing to do with cancer is to extirpate it as soon as the diagnosis is made.

DR. JOHN E. JAMES.—The essayist omits to state the ages of those afflicted with cancer. Whatever we know of the pathology of tumors we know this, that they grow at the time when the epithelial tissues of the body are most active; that is, they grow in malignancy at that time. The benign growths grow at the time when the connective tissue is most active. These are certain facts. If epithelioma are most active at that time of life when the epithelial growth is most active, then we must be cor-

respondingly active with our remedies in that part of life past the middle. We have much more likelihood of curing during the early life of a malignant growth, because it has not developed, and is more of a local irritation. Take away that local irritation and the growth is not apt to return, for at this time it is easily stopped. If we will make a careful study of the periods of growth of these manifestations, it will explain many things. I agree that as soon as it has been established that the growth is malignant, it is time to remove it; the knife is the first remedy for a malignant growth, not the last. The knife does not interfere with the remedy; it does not stop nature's ability to cure or repair. If the local condition is cleared up you have given the remedy a chance. There comes a time when nothing does good; we temporize to please the patient, but that is all.

DR. ALONZO BOOTHBY.—I understand that this paper is intended to illustrate the practicability of removing the uterus. With one thousand cases you may say that the mortality rate is pretty accurately ascertained and, with less than three per cent. in this large number of cases, it makes it a pretty safe operation. Even at this, the mortality comes largely from the very late cases. I believe that in cases where the diagnosis is fairly certain without the microscopic analysis, where the patient has been suffering for a long time and is going down all the time, it is better to remove the uterus right away and not wait for a microscopical diagnosis. If this is done the mortality will not be over two per cent., and maybe not much over one per cent., and in no other way can we cure the patient. I certainly am in favor of operating in suspected cases. You will have some mistakes in the microscopical diagnosis, and may lose the patient by delaying the operation.

DR. H. F. BIGGAR.—There are a few points which have not been touched upon. We see now the result of the discussion at Detroit last year; the pendulum is swinging toward the materia medica man, and the surgeon has not all the say. We do not want to oppose the surgeons; they should not be dissociated or divorced, for both the physician and the surgeon are essential in these diseases, benign or malignant. There was a time when we as homeopaths were maligned; they said we had no surgeons.

We have effectually disproved that assertion, and now we have the *materia medica* man asking that he be recognized to a greater extent—and that is right. Physicians and surgeons should go hand in hand in the treatment and cure of disease. Some of these cases must go to the men who use the knife, but the operation must be followed by internal medication. What is the medication for? To eradicate completely and permanently the disease. I make bold to assert that the malignancy is not local, but constitutional. It is true that you need the knife for the extirpation of the tissue, but you do not cure with it. How many cases of cancer have been removed only to return. Why? Because you have not treated it as if it were constitutional, and constitutional from the beginning. You may take away the morbid growth and purify the system, but you must look to the hygienic, dietetic, and medicinal action of the drug for a complete cure. I know as well as I am standing here that I have cured cancer without the knife, by medication. I think epithelial cancer may be cured. I go farther and take the most malignant form, and I know from my experience and microscopical examination that the diseases were malignant, and the patients are well to-day, and their cure gives me the right to say that cancer is curable. It is the experience of all surgeons that cancer is liable to return after removal. Why? Because you do not get it all out of the system; it has permeated the system. As to the medical cure of cancer, we have historic cases. A prominent one was the case of the fishmonger's wife, examined by Sir Astley Cooper, who found a cancer of the cheek, with glands so involved that he refused to remove it. She was told by a neighbor to take powdered oyster shell and apply it to the cancer, and it cured it, much to the surprise of Sir Astley, who examined her again some months later.

DR. C. E. FISHER.—As to the operative results reported by Dr. Green, I desire to give him especial credit for what he has accomplished under peculiarly adverse circumstances. He is away down South where he has had to battle against old-school bigotry and intolerance, without homeopathic hospital facilities or adequate homeopathic assistance and support, and is specially

deserving for showing such excellent results. His statistics compare remarkably well with those spoken of by Dr. Wood as reported by Dr. Runnels a few days ago, where the mortality rate was about twice that of Dr. Green under the same conditions. Why bring up this old bugbear between the physician and the surgeon, which is largely fanciful? The homeopathic surgeon seldom gets a case of cancer or fibroid until the physician has given the remedies a long and faithful trial. A decision to remove is not a decision against homeopathy, for the medical means have already been exhausted. When we multiply by one thousand, and see how many years of life and comfort have been saved to womankind after the medical means have been exhausted, there is no question that when a malignant disease is giving a woman pain and suffering, and threatening something worse, it is absolutely criminal to wait and not resort to the beneficent influence of surgery.

DR. J. KENT SANDERS.—I should like to see a list of one thousand cases from the medical men. We hear of the brilliant cures by surgery, and also of their deaths; we hear something of brilliant cures by the medical men, but nothing of their deaths. I presume they must have deaths as well as recoveries, and the comparison would be at least interesting.

DR. W. E. GREEN.—When this series of questions was sent out it was with the idea of investigating vaginal hysterectomy, not cancer; the organ may have been removed for hemorrhage, displacement, prolapsus, or any other incurable condition of the uterus. They were not all for cancer. The returns in this respect were incomplete. Remember that statistics vary. We had some very low mortalities reported, and some which showed a higher rate. Those operating exclusively for cancer would probably show the higher rate, which would not be to their discredit. As to uterine cancer treated by drugs, I am sorry that Dr. Biggar spoke as he did. I sent him the list of questions and asked him to give me his results; I was as anxious to include his statistics as those of anyone. Had he given me the report of cases cured medically, I should have been glad to have them. I received a card not long ago, inviting me somewhere to a banquet in honor of someone's one thousandth laparotomy. Now Dr.

Biggar understands pathology ; a man who has performed that many operations *must* understand pathology. And if he, by the symptoms and by the microscope, diagnoses cancer of the uterus, and then risks his patient's life one day with drugs, he is not the man I think he is.

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## SEPSIS FROM RETAINED AFTERBIRTH.

BY S. M. WORTHINGTON, M. D.

WHAT I have to say is a more than "twice-told tale," and I rely solely on its importance for its patient hearing, believing that iteration is a good kind of emphasis. Everyone knows the duty of disinfection of hands, instruments, genitalia, etc., in obstetrical cases, or has some reason to know—it having been rather frequently mentioned, and usually too, with a nonchalant air of self-assurance, as though its accomplishment was the easiest of easy things.

But they who speak of it so, allow practice in transmutation to paper to suffer a "sea change" to something so new and strange, that he who yesterday attended the delivery of a little one in the house of one of our poorer friends, cannot recognize it. There the only basin found was of common tin, that had been bowl and bath-tub to the whole family since and before the first of the other five children was born. The microbes, bacteria, bacilli, cocci, etc., etc., that have dwelt there, and dying left it a rich heritage to their children, are less calculable than the sands of the sea. But it was all you had or could get. The bed of feathers, septic from the beginning, has not been purified by the defecations of five preceding infants born, and reared in some part, therein. The woman's clothing had been worn some days, and in the drawer of the little battered bureau is her only change, beside the scant wardrobe for the expected, laid by with kindly solicitude and maternal

self-denial out of scant funds. Handled oft perhaps with what surgeons call dirty hands, for those of such a mother must touch in toil or love many things unclean. To insist on a change of clothing before the child was born was to make a change impossible after its delivery. Under such conditions, if you had the purest water, the cleanest basin, and all the antiseptics on earth at hand, you could not make a satisfactory examination of your patient without danger of infection from patient's clothing, person, or bedding. Yet the astute teachers in our schools and writers for our journals tell us that he who allows a patient to become infected from external sources is a "criminal." This is rather a harsh word, yet I do not object to it; it may possibly stimulate the careless, and beside it is well to have a "false hobby ridden hard, for it is thereby the sooner ridden to death."

But it is not of this source of sepsis that I mean to speak, but of that other and no less unavoidable sepsis that follows the retention of a portion of afterbirth. Some practitioners tell me that it is possible by inspection of the afterbirth to definitely know in every case whether or not it has been delivered entire, but they are wiser than I am or even hope to be. From experience I infer the average practitioner is seldom positively sure on this point, and that most, like myself, are at times confronted by the dangers arising from a portion of afterbirth unwittingly retained. One cause of this effect,—“for this effect defective comes by cause,”—is undue haste in completing labor's third stage. When the second is ended, a little “masterly inactivity” is excellent. Use no radical means for the delivery of the afterbirth within an hour, nor even Créde's method insistently before lapse of half an hour. What God has joined together so intimately as fetus and mother, let no man put too hurriedly asunder. Make haste slowly. Give Nature time, she did not surrender her diploma in midwifery when you were granted yours. Wait, and when

you are tired waiting, wait some more. It is time cast on the waters of patience that will return to you again with good interest.

But granting you have done your part with discretion and skill, and a portion of afterbirth is retained and sepsis ensues, you have then your curette and apparatus for douching through a return flow tube. Your curette should be dull, and as large as practicable. Your water aseptic rather than antiseptic, for a puerperal woman is scarcely less susceptible to poisons than are microbes. With a vulsellum pull down and steady the womb. The os is usually patulous, and the tube readily introduced to fundus. First let the water flow until it comes back perfectly clear and free from all detritus. Then use your curette. If at all large some difficulty may be experienced in passing the internal os, which will yield to gentle yet firm pressure. Beginning at a definite point, clear uterus out thoroughly all round, washing out the *debris* with douche from time to time. It is occasionally well to occlude the efferent tube for a moment with your hand, making water return by way of the vulva, as its distribution within the womb is thereby extended, and the lower parts of the tract cleansed. But in this some care is necessary, not to force infected matter into the fallopian tubes. Having curetted properly and douched thoroughly, the case is ended, the victory yours. Pack the womb lightly with iodoform gauze, and go home and rest. A chill may follow, due to unusual disturbance of patient, and the immediately increased absorptiveness of the endometrium from abrasion of curettage. It amounts to little, and can usually be avoided by phenacetine grain v. If you have not entirely voided the womb of septic matter at the first attempt, the operation may be repeated in kind until that end is effected. Lack of strength on part of patient is its only limitation. When needed, "Let that eye be your border," and that alone, remembering that while there is some risk of exhaustion



from your efforts, there is a certainty of exhaustion if sepsis continues. In these asthenic cases it is well to give a hypodermatic of strychnia nitras grain  $\frac{1}{16}$  before beginning, and repeat if necessary when done.

For this procedure, some facilities are necessary, and it is more important to know and utilize those at hand than to know the more scientific ones beyond reach. A couch with detachable back is to be found in most houses. Take the back off. Spread over it a common oil-cloth with proper declination for drainage to a receptacle beneath. If the case is pressing, and an oil-cloth not at hand, your buggy apron, well-sponged, may answer. Lacking the couch, place pillows near edge of bed, so as to raise your patient's hips above the rail, and, with your oil-cloth, the bed can be kept perfectly dry, drainage effected, and your work neatly and thoroughly done. But whatever the difficulties or facilities at hand, do the work in some way, for, in such cases, you cannot have a clear conscience until your patient has a clean womb.

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### APPLICATION OF THE FORCEPS.\*

TRANSLATION BY B. F. UNDERWOOD, M. D.

(Continued from p. 281, May, 1897.)

OBLIQUE AND TRANSVERSE APPLICATIONS; THE OCCIPUT BEING IN THE RIGHT HALF OF THE PELVIS.

*Anterior Right Oblique Application.*—Vertex at the inferior strait in the occipital right anterior position. The flexed head is at the inferior strait, but has not engaged, for rotation has not been made.

The occiput is forward to the right, in the direction indicated by the ileo-pectineal eminence; the bregma backward to the left; that is to say, the right oblique diameter

\* From the French of Professor Farabeuf and Dr. Varnier.

of the pelvis is occupied by the sub-occipito-bregmatic diameter of the head, and the left oblique by the parietal.

The ears, marks of certainty, which may be felt, are turned precisely as the ends of the left oblique diameter; they indicate that the parietal bosses and the cheeks, which should be embraced in the fenestra of the instrument, are equally turned; those of one side to the right and backward; those of the other to the left and forward; toward the left ileo-pectineal eminence, behind the horizontal branch of the left pubic bone.

Separating the lips of the vulva, the anterior parietal suture can be seen obliquely turned (the left, in this, the occipital right anterior position) while the posterior parietal, to which it is necessary to apply the first blade, is deeply hidden in the sacro-iliac cavity, in front of which it rises nearly to the height of the superior strait.

Up to this point there is a striking analogy between the right anterior and the left posterior positions, the only difference, which is a capital one, it is true, is in the direction of the occiput—in this position, forward, which simplifies the rotation and permits of the placing of the concavity of the forceps in the proper position at once. In other respects, as the right branch first, necessity of uncrossing and recrossing the handles, they are similar: nevertheless, the position should be studied in all of the phases of the application of the forceps to this position, right anterior, as if it were entirely unlike any other. Familiarity with the forceps is obtained only by many repeated applications in all possible conditions.

The head should be taken in its long diameter and by the sides, the concavity of the forceps being turned toward the neck, which is to be brought upon the median line. The neck is in front and to the right; the grand axis of the head is still in the axis of the excavation, and consequently, the descendant pole is near to the coccyx. Knowing this,

hold the forceps upon the exterior, in both hands, in the position which they would have when the head has been properly grasped, figure 61.

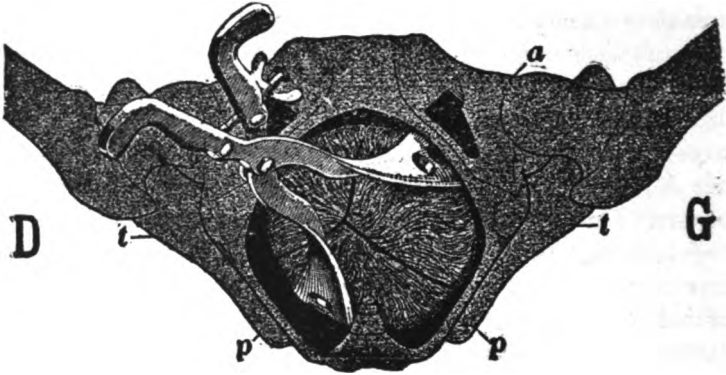


FIG. 61.

Figure 61. Vertex at the inferior strait in occipital right anterior position, forceps properly applied; pelvic concavity forward, like the occiput, the right, notched branch, to the right and backward, the left, pivoted, branch, to the left in front. The latter being anterior has to be introduced second, and consequently crosses above the first; articulation is therefore possible only after the blades have been uncrossed and recrossed with the first blade above the second.

The right anterior direction of the concavity of the instrument makes the latter oblique; the right blade, the upper, held in the right hand, should have its blade, the lower, backward to the right; the left blade, the lower, held in the left hand, should have its blade to the left and forward, behind the ileo-pectineal eminence.

First general rule.—It is necessary to first introduce the blade which will be posterior, for the purpose of having all facility to place it properly, for upon its proper placing the success of the operation depends.

In the present position, occipital right anterior, it is the right blade.

Second general rule.—The blade introduced secondly can only be introduced above the first, so that the handle will necessarily cross above that first placed.

In the present case, occipital right anterior, the second blade is to the left, which carries the pivot, and which crossing above the first, the notched, does not offer the pivot for articulation. To make the articulation possible, the handles must be uncrossed and recrossed, passing the right blade above the left. Therefore the right blade, the notched, held in the right hand, will be the first introduced, preceded and guided by the left hand, and will be properly placed backward and to the right. This done, the left blade, pivoted, intended to be placed to the left in front, opposite the first, will be introduced upon the right guiding hand, wherever it is possible to do so, that is to say, to the left backward, to the right even in front. Finally, this blade will cross above the first: it will be necessary therefore to uncross and recross them to be able to articulate them.

Such is the programme of the repetition which is to be simulated upon the outside. As usual, separate the blades of the forceps, and lay them, made antiseptic, the blades oiled, conveniently at hand, upon a napkin which has been dipped in an antiseptic fluid.

#### APPLICATION OF THE FORCEPS.

First, notched branch, the right, guided by the left hand, held in the right.

*Introduction of the Guiding Hand.*—Introduce in the usual manner, the left hand, since the first blade, the posterior, to which it is to act as a guide, is the right. Proceed in the same manner as has already been explained. To reach the ear, which is lateral and posterior, carry the hand (including the thumb) between the coccyx and right ischium, back-

ward, to the right. Fatigue the vulva with patience, to accomplish the end without pain and without danger: examine carefully the fetal part to recognize its character, and finally enter the uterine orifice, avoiding passing the fingers into the peri-uterine culs-de-sac.

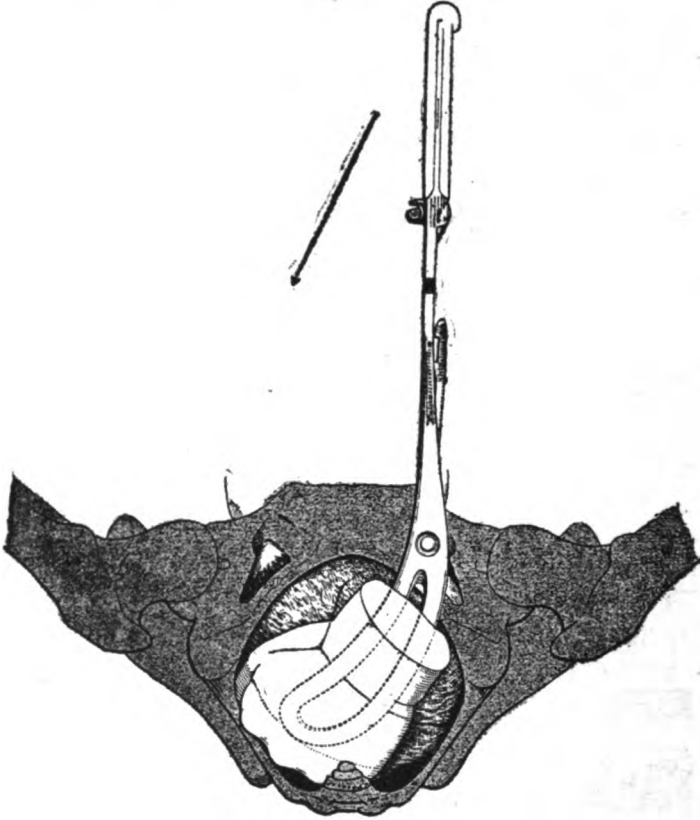


FIG. 62.

Figure 62. Vertex at the inferior strait in occipital right anterior position. Introduction, obliquely backward to the right, between the coccyx and the ischium, of the first guiding hand (the left, including the thumb) and of the first blade the right.

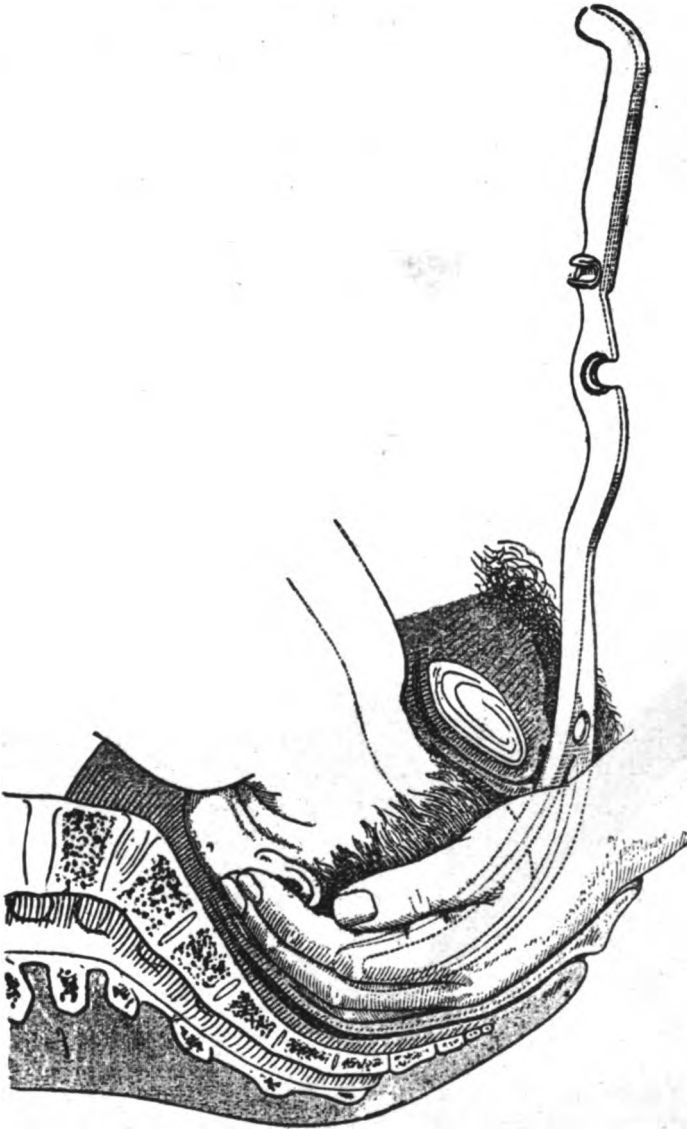


FIG. 63.

When the entire hand has been introduced, so that the vulva encircles the wrist, the neck of the uterus will have

been passed, and the ear, of which the lobule is nearly to the height of the malar bone, which should be embraced in the fenestrum of the blade, may be easily found and examined. Figure 63.

Figure 63. Vertex in occipital right anterior position, in a median section of the pelvis, seen to the right and

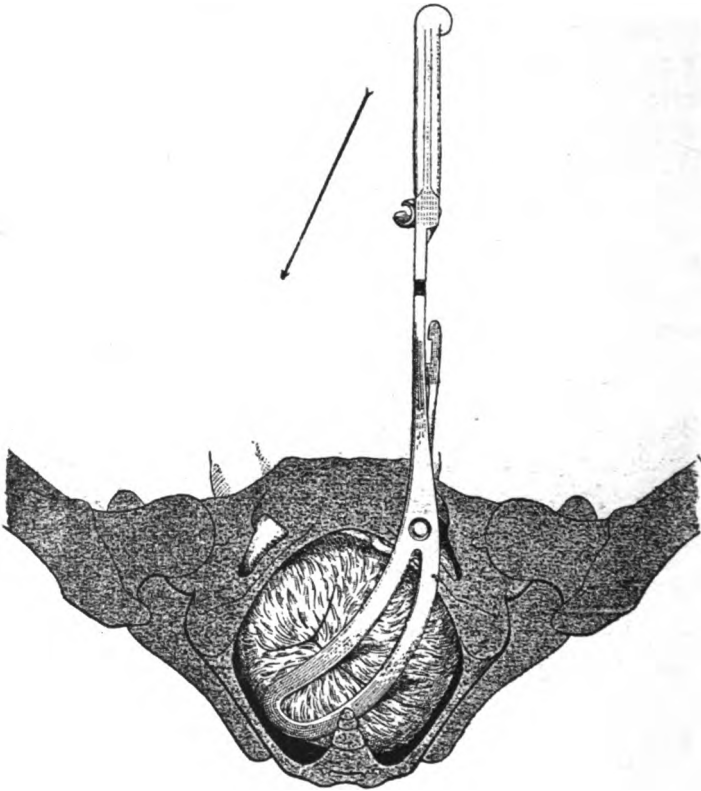


FIG. 64.

horizontally. Manner in which the first guiding hand, the left, should penetrate. Notice that it covers the line of application, the parietal eminence and cheek; that the

index finger is upon the ear; that the fingers have passed the uterine orifice one-half their length; and that the blade is introduced without danger.

*Presentation, Introduction and Placing of the Blade.*—When, and only when, the guiding hand is properly placed, as shown in figures 62 and 63, present and introduce the right blade, notched, according to the directions already given—blade in axis of the guiding hand; the other hand obliquely lowered to descend outside of the left forearm. Remove the guiding hand and let the branch rest upon the fourchette.

Figure 64. Vertex at the inferior strait, in occipital right anterior position; handle directed a little to the left of the median maternal plane, showing the relation of the blade with the head at the moment of introduction. That the blade should enter properly upon parieto-malar line, here obliquely median, it is necessary to lower the handle obliquely in the direction shown by the arrow.

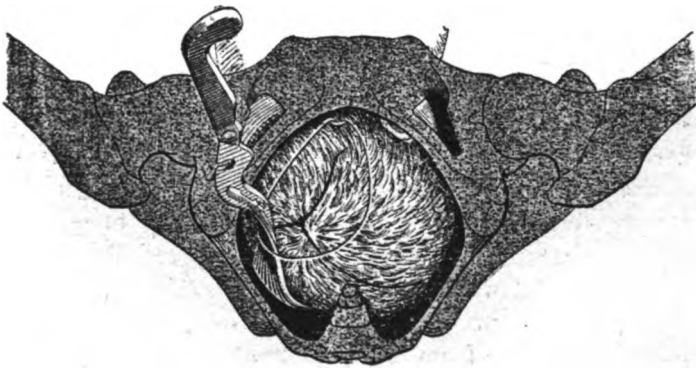


FIG. 65.

Figure 65 shows the result of the first step of the application. The handle of the right blade is slightly raised, nearly horizontal, lightly turned to the right of the mother. Its hook, which, perpendicular to the taking surface of the



blade, shows the direction of this surface, is directed upward to the left.

Figure 65. Vertex at the inferior strait, occipital right anterior position. The first blade is in place, backward to the right, upon the parieto-malar line. The handle is sustained by the vulvar ring (an assistant should hold it immovable); the hook is obliquely ascendant, directed like the taking face of the blade. This is imperfectly represented, for the pelvic concavity of the forceps can only be partially seen.

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### THE MORTALITY OF BABIES.\*

BY WILLIAM MORE DECKER, M. D.

**D**R. DECKER distinguished between infant mortality and baby mortality, because baby mortality has never, to his knowledge, been considered by the State or local boards of health in their regular reports. The State and some of the local boards of health report infant mortality as "deaths under five years." Some of the local boards list the death by ages, but as a rule, with all boards the mortality of the babies enters into the general annual mortality without distinction. The mortality of babies is consequently covered up and lost in the annual mortality and the total mortality under five years of age, otherwise the excessive death rate would be generally known and receive the attention it deserves.

The word infant, as used by the legal fraternity, is a comprehensive term of broad application, and it is used in reference to a life from birth to twenty-one years of age. Babyhood covers the period of life from birth to two years of age. So that a child two years old or younger would, medically speaking, be a baby, and a child five years old would be an infant, but not a baby. The mortality of

\* Abstract of a paper presented to the Section in Pedology of the American Institute of Homeopathy, Buffalo, 1897.

babies is the mortality under two years of age. State and local boards of health should furnish us a special annual report on baby mortality. The death rate should be estimated on the total number of births. The State receives no birth certificates from the cities of New York, Brooklyn, Yonkers, Albany, and Buffalo; and no births are listed in annual reports of the State and local boards of health.

In New York City, last year, more than 82 per cent. of all the deaths under five years of age were babies. In Buffalo the baby mortality in 1896 was over 81 per cent. The total number of children that died in New York State in 1895, under five years of age, was 42,003. The baby mortality in the State last year was about 38,711. The baby mortality is therefore over 92 per cent. of the entire mortality under five years of age. That leaves a balance of less than 8 per cent. to die out of babyhood, between the ages of two and five. In one year 38,711 babies die, while within the same period only 3292 deaths occur between the ages of two and five. That is over 11 deaths in babyhood to every 1 death that occurs in subsequent life up to five years of age. About 92 per cent. of all the children that die under five years of age are babies. That means that out of every 100 deaths, 92 are babies, and in every 1000 deaths, 920 are babies. This alone is sufficient ground upon which to demand a special yearly report on the mortality of babies.

The mortality of our cities and towns would be small were it not for the baby mortality, which is about one-third of the whole. Take the baby mortality out of the annual Buffalo death rate, and it would be about 8 per 1000 instead of 13.

In 1895 the deaths in New York State were 121,735. The total baby mortality for 1896 is estimated at 38,711. If the baby mortality of 1895 was as great then, it was nearly 32 per cent. of the total mortality of the State.

Let us consider the maritime district—one of the eight sanitary districts into which the State is divided, and which includes two great cities, Brooklyn and New York, and show the effects on that. This district in 1895 had a population of 3,500,000, with total number of deaths 73,863. The baby mortality is  $31\frac{1}{7}$  per cent., or 23,514; that taken from the total mortality reduces it to 50,349, and that divided by the number of thousands in the population gives an annual mortality per 1000 of 14.38, instead of 21.10, or a deduction of almost one-third in the mortality.

The third lesson taught by baby mortality is that the deaths are over one-fourth of the births, and that the mortality should be estimated on the births. The total number of babies born in Yonkers, Brooklyn, New York, Albany, and Buffalo in 1896 was 88,287; that added to 59,032—the number of birth certificates received by the State—makes a total of 147,319 babies born last year. Of that number about 38,711 died. In New York City the deaths last year were 25 per cent. of the births. In Buffalo the deaths were 17.22 of the births.

The mortality of babies should be estimated on the baby population, not including premature or stillbirths. Now the baby mortality of the State is about 260 per 1000 births. Contrast that with a mortality from all causes out of babyhood of only 12.43 per 1000 for the State, or of only 8 per 1000 for Buffalo, and the difference is marked.

The fourth lesson taught is that the second summer is less deadly than the first—three or more babies die the first year to one in the second year. The teeth have little or no influence to increase the mortality of babies. In the entire State the mortality in 1896 was as follows: 29,570 babies died in the first year of life, and 9141 died the second year.

The fifth lesson is that the mortality is excessive, and much of it is unnecessary and avoidable. Ninety-two per cent. of all the deaths under five years are babies. Nearly

one-third of the total mortality are babies. The deaths every year under two years of age exceed one-fourth of the babies.

The deaths of the first year of life are 20 per cent. of the births.

The mortality the first year is over three times greater than the mortality of the second year; and the mortality of the second year is nearly three times greater than between two and five years.

The deaths the first year are more than 24 per cent. of the total annual mortality of the State, and over 70 per cent. of the mortality under five years of age. The deaths between two and five years of age are less than 3 per cent. of the total mortality of the State, and less than 9 per cent. of the total mortality under five years of age.

The opinion has obtained that this mortality is unavoidable because due to the natural frailty of early life. Away with such belief! The mortality is excessive, and this excessive mortality is not so much due to the tender years of budding life as it is to the ignorance and neglect of those who care for and treat babies. According to the *Medical Times* (June, 1897), 3000 abandoned babies are cared for by the city of New York. One hundred and twenty babies out of every thousand are found by the police in all sorts of places. The list of deserted babies is said to be on the increase, and the mortality among them is large. This mortality cannot be attributed to the frailty of babyhood. Hereditary mortality is a blight from a diseased ancestor.

Improper feeding is the most deadly cause of this augmented mortality. The question, What shall we feed baby? is of no more importance to many than, How shall we feed baby? Cholera infantum would not afflict babies were there no errors in diet. Mortality from feeding babies is larger than the mortality from not feeding them.

In this city in 1896 there were 1139 more births than in

1890, yet the baby mortality was reduced '556 in the first year of life. The mortality was not reduced in the second year of life. The total mortality under five years of age was reduced 507, the total annual mortality was reduced 572. The deduction in annual mortality only exceeded the deduction in baby mortality by 16 deaths, thus showing clearly that the difference in mortality for those two years was mainly due to change in the baby mortality under one year of age.

This change was brought about by the Board of Health sending out printed instructions on the care of babies to those who had them; and last year they took a step further for the welfare of the babies, when they condemned the nursing bottle with the long rubber tubing. That act, if enforced, will lessen still more the mortality of the city.

When the mothers and the profession learn wisdom, the death rate of babies will be less than the mortality in childhood and in subsequent years, for nature, like a guardian angel, protects babyhood from most of the children's diseases that attack life when the baby period has passed. I verily believe that a baby born healthy, when properly managed, stands a better chance of surviving babyhood than a child four or five years old does of surviving puberty.

Babies die because they are not cared for properly. Their environment and food are too artificial. Their baby nature is perverted; it is not understood, and so the little lamps of life flicker and go out.

## DATA.

1896, Total births, Yonkers,	1,121 ;	total deaths,	758
" " " Brooklyn,	21,424 ;	" "	22,501
" " " New York,	55,623 ;	" "	41,622
" " " Buffalo,	8,507 ;	" "	4,452
" " " Albany,	1,612 ;	" "	2,103
" " " State,*	59,032 ;	" "	....
	<hr/>		<hr/>
	147,319		71,436
1896, Total births in State.....	147,319.		
1895, Total deaths in State... ..	121,735.		

	Deaths under One Year.	Deaths between One and Two Years.	Total Deaths under Five Years.
1896, New York State *...	11,806 †	3,648 †	(42,003 year 1895)*
" Albany .....	322	99	559
" New York.....	10,677	3,211	16,807
" Brooklyn.....	5,468	1,735	9,007
" Buffalo.....	1,073	392	1,795
" Yonkers.....	224	56	337
	29,250	9,141	28,505

Total deaths under two years of age..... 38,711

Total deaths between two and five years.... 42,003

For other statistics see the Sixteenth Annual Report of the State Board of Health.

## BUFFALO.

	Total Deaths under One Year.	Total Deaths between One and Two Years.	Total Deaths under Five Years of Age.	Total Annual Deaths.
1890.....	1629	386	2302	5024
1896.....	1073	392	1795	4452
	556		507	572
				556
				16

Total births, 1896..... 8507

Total births, 1890..... 7368

1139

Population in 1896, 350,000 ; mortality per 1000, 12.73.

Population in 1890, about 260,000 ; mortality per 1000, 19.2.

Mortality reduced  $6\frac{1}{2}$  per 1000 in 1896 by reducing the baby mortality.

\* The five cities named not included.

† Estimated 20 per cent. of the births, *i. e.*, 20 per cent of 59,032.

## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

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THE PHARMACOPŒIA OF THE AMERICAN INSTITUTE OF HOMEOPATHY. Published by the Committee on Pharmacopœia. Boston. 8vo, pp. 674. \$4.50 and \$5.25.

This work has been in preparation since 1888, when a committee was appointed by the American Institute of Homeopathy for the purpose of preparing an authoritative and standard ard pharmacopea. The years which have been spent in the work are justified by this handsome and valuable work, which, to use the trite expression, fills a long felt want.

The first section of the book treats of general pharmacy and the methods of preparing drugs for homeopathic prescriptions, with the tests for ascertaining the purity of the menstrua employed. The second section, special pharmaceutics, gives the description of more than seven hundred drugs, with the method of preparing the tinctures, dilutions, or triturations. The descriptions of the various drugs are full and complete, and with their medicinal history furnish a fund of information to the physician regarding the remedies he uses. As the work is intended for physicians as well as for pharmacists, this portion of the book has been made more comprehensive than would have been necessary in a work intended for pharmacists alone.

The third section is composed of tables for reference, with a list of medicines and their pronunciation.

To secure an unvarying standard of strength in the preparation of remedies the British method of preparing tinctures has been adopted. The moisture in the plant is estimated as so much inert solvent, making the weight of the dried root, leaf, or flower the quantity to be considered. To secure uniformity of tinctures and triturations, it is directed, where possible, to have the tincture represent one-tenth of the strength of the crude drug when dried. Thus one minim of the tincture of a plant holds what is soluble of one-tenth of a grain of the plant when dried ; by this

plan the tincture really becomes the first decimal dilution and should be so regarded. The dilution made from the tincture is therefore the second decimal. In the preparation of triturations and dilutions the decimal scale has been adopted, thus making possible many intermediate strengths or potencies.

In the preparation of triturations the method of Hahnemann is still adhered to, with the exception of using one part of the drug to nine of sugar of milk, and instead of adhering to the one hour rule, the time allotted to triturations is determined by the nature of the substance and the fineness to which it is possible to reduce it. If an insoluble substance this can best be determined by the microscopic test. The notes upon the preparation of triturations are full of interest and will repay careful perusal.

In nomenclature, while each old Latin titular name has been retained, the present chemical name has been added to the title of headings. In weights and measures the metric system has been adopted.

**MANUAL OF URINARY ANALYSIS**, Containing a Systematic Course in Didactic and Laboratory Instruction for Students, together with Reference Tables and Clinical Data for Practitioners. By CLIFFORD MITCHELL, A. M., M. D., Professor of Renal Diseases in the Chicago Homeopathic Medical College. Illustrated. Chicago : Era Publishing Co., 1897. 325 pp. Cloth, \$1.75.

**MYSTIC MASONRY ; OR, THE SYMBOLS OF FREEMASONRY AND THE GREATER MYSTERIES OF ANTIQUITY.** By J. D. BUCK, M. D., F. T. S., S. R. 32°. Author of "A Study of Man," etc., etc. With illustrations. The Robert Clarke Company, Cincinnati, O.

In this book, which, while possessing the greatest interest for members of the craft, is not intended for members of the order alone, but for all who are interested in the source and origin of the knowledge which has come down the ages, the author traces the connection between modern Freemasonry and the Ancient Mysteries, along lines which, although broken, show the intimate relation. "The true Mason" is, as the author shows, "a practical philosopher," and the craft founded upon philosophy and religion.

Whether we accept the author's conclusions or not we must



admit that he has produced a most interesting book, one which furnishes material for serious thought and leads the mind into one of the most fascinating lines of speculation. The book is written in the characteristic, graceful style of the author, and the reader who enters upon the introduction will be loath to quit until he has finished it.

**THE USE OF THE OBSTETRIC FORCEPS.** By SHELDON LEAVITT, M. D., Professor of Obstetrics and Gynecology in the Hahnemann Medical College and Hospital of Chicago, etc., etc. Illustrated. Chicago: Era Publishing Company, 1897. 112 pp. \$1.00.

This little book is a clear and concise treatise upon the use of the obstetrical forceps, by a past master in the art of using an instrument which in skillful hands and wisely used is a great conservator of both maternal and fetal interests, but which unskillfully or unwisely used is capable of producing permanent injury. In the words of the author, "in no department of surgery is a close and protracted study of the principles and technique of greater importance than in obstetric instrumentation." The book is of a convenient size and may be profitably carried by the obstetrician for study in leisure moments and may be read and reread with profit.

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## Malaria Malaria.

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**Carb. Veg. in Post-Partum Hemorrhage.**—Profuse hemorrhage with irritation of the bladder and rectum.

**Equisetum in Enuresis.**—Dr. Waldran.—Pain in region of the kidney. Bladder feels as if distended, not relieved by micturition. Burning in urethra when urinating. Excess of mucus after standing.

**Echinacea in Uterine Disease.**—Dr. C. T. Otis.—Uterus: Puerperal septicæmia; discharges suppressed; temperature high; abdomen sensitive and very tympanitic; in all purulent and septic conditions whether contagious or infectious. In this condition echinacea should have the first place.

**Alumina in Leucorrhœa.**—Dr. McElwee.—Profuse yellow, corroding discharge ameliorated by cold washes, accompanied by burning in rectum and pain in back as though a hot iron were thrust through the lower vertebra.

**Cundurango in Mammary Tumors.**—It is of use in very hard, painful tumors of the breast associated with ulcers in the corners of the mouth; this soreness and cracking in the corners of the mouth is characteristic of the drug.

**Phellandrium Aquaticum in Painfulness of the Breast.**—Dr. W. A. Dewey.—Phellandrium is a useful remedy in painfulness of the breast after the child has nursed it dry. Pains seem to course along the milk ducts. This is similar to croton tiglium. Under this remedy the pains shoot through to the back upon nursing.

**Nitric Acid in Scarlatina.**—Dr. McElwee.—There is from the beginning an acrid discharge from the nose; the breath is extremely putrid; corners of mouth and nose are full of ulcers; tonsils swollen, often producing sensation of splinter in throat on deglutition; urine smells very strong—like horse's urine, or like the smell from a livery stable on a hot day.

**Rhus Aromatica in Enuresis.**—Dr. Worthington.—It is practically a specific for this troublesome complaint. He does not look for symptoms, but when he has a case of bed-wetting to treat he gives rhus aromatica in ten-drop doses. It has been also recommended for other complaints, and may be useful in them, but in diabetes, dribbling of urine, incontinence of urine, and enuresis it stands forth as a strongly marked remedy.

**Lycopodium in Dysmenorrhœa.**—Dr. M. Powels.—In a case of sudden suppression of menstruation from fright, characterized by intense restlessness of the patient, could not lie or sit still, prescribed lycopodium 43 m. (Fincke), by olfaction, and in fifteen minutes patient was asleep and menses returned about eighteen hours after, and continued to the end without pain.

**Nux Vomica in Whooping Cough.**—Child cross, impatient, frequent hard dry cough in morning; child puts hand up to head while coughing. No expectoration at night and in morning, but expectoration during day and evening; expectoration of yellow or gray mucus, or clear dark red blood; suits the catarrhal stages; frequent nose bleed, injection of conjunctiva from cough.

***Apis Mel. in Abortion.***—Professor L. L. Danforth.—Threatened miscarriage; abortion during the early months (fourth month); stinging pains in ovarian region until labor pains ensue; scanty urine; no thirst; profuse flow. Stinging pains occur in one or other ovarian region, more and more frequently till labor pains are produced; sometimes flowing and finally abortion.

***Phosphorus in Ovarian Pain.***—Dr. McMichael.—Pain in left ovarian region, down the inner side of the thigh, worse during menses. Leucorrhœa acrid, milky, excoriating; burning sensation between shoulders. Anxiety and restlessness, indifference to work or study, sleepy during day. Sleeplessness before midnight. Eyes sunken, with blue rings around them. Burning between shoulders. Suited to tall, thin, dark-haired women; young girls who grow too fast; nervous persons.

***Palladium in Ovarian Neuralgia.***—Dr. E. V. Moffat.—Maiden lady, æt. thirty-five years. Ten years' standing. No relief from successive allopathic physicians and some noble attempts from two homeopaths, who tried most of the remedies. There were no collateral symptoms on which to prescribe. Clinical symptoms: Severe, persistent pain in the right ovary. A two dram vial gave her absolute comfort for six months, and now after a year an occasional dose relieves at once.

***Sepia in Whooping Cough.***—Dr. T. S. Turner, Med. Cent.—I recall a most aggravated case in a child of about nine months. It was about the second week, and the case had grown worse from day to day, and when I saw it seemed a most hopeless one. While trying to get a little history it had another "coughing spell," and it "coughed the breath out of the body." There was no respiration of air, and that was why they thought every "spell" would be the last. Sepia 6x made a most brilliant cure. I have verified this symptom, and when we find that peculiar cough sepia will not disappoint us.

***Echinacea Angustifolia in Angina.***—Dr. C. T. Otis.—Phlegmonous inflammation of the tonsils; tonsils, purple or black (the more strangulated the circulation the better echinacea is indicated); a gray exudation on the tonsils and throat extending into the posterior nares and into the air passages; much dryness of the throat; exudation of watery fluid which corrodes the

healthy tissue seems to be the serum from the blood exuding from cracked or ulcerated surfaces ; very offensive breath.

Noisy sawing respiration, impeded from membranous deposits ; respiration from 40 to 60 per minute ; face purple.

***Esculus Hip. in Backache.***—Pain, mostly in the sacro-iliac region, with a dull weariness ; moving about causes the back to "give out," and unfits one for business ; walking is almost impossible ; the spine feels weak. You might expect to find an inflamed cervix, retroversion, prolapsus, great local tenderness, with heat and throbbing ; a leucorrhœa of a dark yellow color, thick, sticky, and acrid ; the sacrum, back, neck, head, chest, and abdomen all seem in sympathy with the rectum and its vessels. The patient is generally worse from cold air, washing in cold water, and in the winter ; generally better in summer.

***Ferrum in Hemorrhages.***—Dr. Evans.—Hemorrhages from all parts of the body have frequently found a curative agent in ferrum ; epistaxis, hemoptysis, hematemesis, menorrhagia, hemorrhoidal flow, etc., and in all such instances the blood will be found to be dark in color and passive in character. The menses are either dark and clotted, or pale, thin, and watery, and are not infrequently irregular or suppressed. The climacteric period, with its attendant profuse hemorrhages and multiform symptomatology, among which sudden flushing is a prominent feature, would seem to suggest its use at this period.

***Apis Mel. in Measles.***—Dr. McElwee.—Patient cannot bear the least heat, and rebels because the kind-hearted mother or nurse insists that he shall be covered up warm, shall have nothing but warm drinks, and exist in an insufferably (to him) hot room. Although there is much fever, there is little thirst, and what water is drunk must be very cold. There is usually, if not always, swelling of the lower extremities, oftentimes puffiness under the eyes, and albuminuria. The rash is very slow in appearing, or perhaps may have appeared and receded. The latter being the case, the patient has a waxy look. If brain symptoms supervene, there is usually effusion into the cerebral ventricles, accompanied by the *cri-encephalique*.

***Bromum in Croupous Diseases.***—Hahn.—It is indicated in either diphtheritic or idiopathic croup. It is rarely called for

in the early stages ; but when the febrile symptoms have subsided, the patient is weak, perspiring, has a hard, tight cough, which is spasmodic, with suffocative attacks and sometimes rattling of mucus in larynx ; the element of spasm is to be considered a characteristic of the drug. Bromine follows well after iodine. Spasmodic croup symptoms, starting up as if choked, greater when drinking ; every inspiration provokes cough. Asthma in suffocative attacks ; it seems as if the breathing were hindered by spasmodic constriction. In pneumonia, for suffocative attacks ; cannot expectorate. Asthma greater at sea.

***Hydrozone in Vomiting During Pregnancy.***—Hydrozone may be used with excellent effect in the treatment of so-called incoercible vomiting in pregnant women. The method of treatment is only a practical modification of inhalations of oxygen, already successfully resorted to in such cases by Dr. Pinard, professor of clinical obstetrics at the Medical Faculty of Paris.

Hydrozone is administered internally in the following manner : The patient is ordered to take at meals ordinary water, or water mixed with wine, containing from 15 m. to a dram of hydrozone to the gallon. In the cases in which it has been used the vomiting, anorexia, and feeling of weight in the stomach soon subsided. At first these symptoms reappeared as soon as the medication was suspended, but they were definitely dispelled by a sufficiently prolonged treatment.

***Secale Cornutum in Uterine Disorders.***—Dr. Cowperthwaite.—The powerful action of ergot upon the gravid uterus is too well known to require mention. Its action is upon the unstriped muscular fiber, and therefore its effects are displayed to a remarkable degree during the enlargement of that organ in pregnancy, especially in exciting contractions and expelling the contents. To avert such a disaster, secale is often the true homeopathic remedy, but to give it in parturition, in order to hasten delivery, is an inexcusable practice. Sometimes if the pains are prolonged and ineffectual, irregular and spasmodic, or weak, a dose of the potentized drug may be of benefit. The use of ergot to contract the bleeding vessels after delivery, and thus to prevent or check a post-partum hemorrhage is a mechanical measure perfectly justifiable. Secale has often cured fibroid tumors of the uterus, as my own experience verifies.

**Nenning's Symptoms.**—Dr. W. A. Dewey.—As to the value of Nenning's symptoms, Hughes says, "We have the testimony of three of the most industrious symptomatologists of our school—Boenninghausen, Hering, and Wilson—that they have found no reason to distrust Nenning's symptoms, and have used them as satisfactorily as those of other observers. No statement to the reverse of this has come from the other side; so that we may accept Nenning's contributions as at least provisionally established to be good and sound additions to our pathogenic material.

"Among the remedies proven were graphites, sulphur, and ammonium muriaticum, and if you will turn to these remedies in Allen's Cyclopaedia, you will find that most of the symptoms given there are from these provings. He also proved zinc and dulcamara. His symptoms were incorporated into Hahnemann's nervous diseases, and Hahnemann knew what Nenning was. He was a careful prover; he said it was a matter of conscience with him not to omit the smallest particular, and thereby frequent repetitions have come, but our knowledge of the action of these remedies comes from his provings. They have stood the test of experience and the many cures made by them are an evidence of their genuineness and value. In certain parts and organs of the body we have but few symptoms outside those of Nenning, so we can rely upon them and the correctness of their proving."

**Sepia in Chronic Uterine Disorders.**—Dr. A. C. Cowperthwaite.—In a general way it may be safely said that sepia is the most valuable of all our remedies in the treatment of the more common chronic uterine ailments. Its sluggish action, the torpidity and depression resulting from its use, and it feebly pronounced and isolated symptoms, all are in harmony with the local conditions to which it gives rise, and which it is equally efficacious in curing. Sepia stands at the head of all remedies in the treatment of uterine displacements, especially prolapsus, with engorgement and the characteristic bearing down sensation, as if the organ would protrude; has to cross her limbs to prevent it. It has cured many cases without this symptom when other sepia symptoms were present. A sensation of "goneness" is very characteristic. It is the chief remedy in chronic endome-

tritis and uterine leucorrhœa, with pain in back, yellow or milky excoriating discharge, etc. It is often useful in menstrual disorders, especially amenorrhea. A valuable remedy during pregnancy and childbed, while nursing, and for sub-involution and other troubles arising from too oft repeated labors and miscarriages. I depend very greatly upon the cachectic appearance of the sepia patient—a dirty white waxen look, with yellowish brown spots on the face, especially across the nose and upper part of the cheeks.

*Hyoscyamus in Puerperal Mania.*—Dr. Craig.—The only case of this kind that ever came under my notice, although a very unpromising one, had a very satisfactory ending. The patient, a woman of about twenty-four, had been confined a week previous, and had shown symptoms of mania from the day of her confinement. I was called in counsel, because she had not slept during the week, and at this time she had become violent and had driven the attending physician from the house with an uplifted chair, because she had overheard him inform her husband that he was about to give her a hypodermic injection of morphine.

I prescribed hyos. 3x without benefit, then the 2x, and finally the tincture, without any benefit whatever. I then administered a placebo to give me time to review the case, and, as I could make out nothing but a hyoscyamus case of it, I gave her the 200th of that drug in the afternoon of the third day, which made two weeks that she had been deprived of sleep. About nine o'clock she fell asleep, and did not awake until morning. After three or four days of improvement she became despondent, and wanted to get out of doors, when I changed the remedy to pulsatilla, and dismissed her cured within a few days.

This case had a hopeless look because of her family history: her grandfather had died in the insane asylum at Kalamazoo, Mich., and her mother and two aunts had each been insane, and for that reason the prompt response to the properly selected remedy and potency was gratifying.

There was one thing in this case that was noticeable, that I have frequently seen in other cases, and that is that a remedy may be indicated when the so-called leading symptom may be entirely absent. There was no disposition in this case for the

patient to uncover herself, nor was there any indecency shown either by her language or actions, as there usually is when hyos. is indicated, but other symptoms, which I cannot now recall, decided in favor of this remedy with the results as I have stated.

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## Gynecological Etchings.

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**The Curette and Morbus Cordis.**—Dr. Resnikoff (Monats. f. Geburtsh. u. Gynäk.) warns gynecologists against scraping the endometrium for menorrhagia or metrorrhagia until the patient's heart has been examined. When organic disease of the heart exists the use of the curette is often followed by an increase, instead of a diminution, of the hemorrhage.

**Death in Hysteria.**—Drs. Fournier and Sollier—Journ. de Méd.—A fatal termination may sometimes result from the different effects of hysteria, and it is quite a mistake to look upon the disease as always having a favorable prognosis so far as life is concerned. As previously pointed out, death may be due to spasm of the glottis so severe as to require tracheotomy. Sollier records an instance of very severe asphyxia in a child aged six, which rapidly gave way to faradism, and Fournier records a case of a girl aged twenty showing a similar condition, being saved from death on one occasion by faradism, but who afterward died from a similar attack. Expectant treatment in hysteria, more particularly when there are laryngeal manifestations, is anything but safe. In hysterical angina pectoris also, although in this affection the prognosis is extremely favorable, a case is quoted under Potain's care in which death took place, and in which on post-mortem examination absolutely nothing was found. In hysterical anorexia there is sometimes a fatal termination, and even should recourse be had to artificial feeding, there seems to be no power of absorption. The wasting continues and the patient dies. Forcible feeding in such cases is not without danger, and one of their patients who presented a marked degree of anorexia expressed a wish for some cheese, and died the same evening that she ate it. Sudden death may also occur after hysterical vomit-



ing, and they give the notes of one such case, no lesion of any kind being found on post-mortem examination. Vaginal hysterectomy is particularly fatal in hysterical cases.

*Minor Gynecology.*—Dr. John Byrne.—I believe that what the majority of our associates most desire, is not the details of a complicated abdominal section, or a vaginal hysterectomy, but the discussion of such topics as might enable them, as well as the general practitioner, to become familiar with, to diagnosticate, and to treat intelligently and successfully, such cases as we meet with daily in our office and private practice generally.

Indeed, there is no exaggeration in surmising that, at the present day, the number of societies engaged in the study of the diseases of women far exceed that of all the distinctly recognized gynecologists of forty years ago. And yet, with all this display of care for the physical well-being of women, but little interest seems to be manifested in their sexual infirmities unless such as demand or directly lead to some heroic exploit in abdominal or pelvic surgery. As for the cases which we meet with in everyday practice, and which constitute, perhaps, ninety per cent. of all the patients who seek advice and treatment at our residence, nay, the very cases on which many an enviable reputation has been founded, and the successful management of which seldom fails to be appreciated, are rarely discussed or considered. In a word, if we are to judge by the reported proceedings of these societies, it would seem as if minor gynecology, by which I mean the less grave maladies of women, had become either obsolete or too old-fashioned to merit attention. And what is the natural result of all this? Those only whose professional labors are mainly if not wholly confined to the treatment of diseases of women, and who are daily brought in contact with a large number of these cases, can fully realize how numerous are the examples of slipshod, meaningless, and often mischievous treatment, to say nothing of grave errors in diagnosis, which are to be met with almost daily. Such a state of things, I need not say, could hardly exist to the same extent in any other department of medicine or surgery than ours, and for obvious reasons.

No living woman, not even the new one, however transformed, can ever hope to attain any degree of proficiency in the art of

auto-diagnosis, so far as her sexual organs are concerned; and more's the pity, say I. Here, however, I find myself almost unconsciously touching on a very delicate phase of the subject, so I shall merely remark that, under existing circumstances, and since a large proportion of all ordinary uterine diseases, especially in their primary stages, are apt to, and as a matter of fact do, fall into the hands of the general practitioner, it seems to me that the latter has certain claims which cannot and ought not to be ignored. Lest the comprehensive title by which these hurried and ill-digested remarks have been announced might mislead as to their scope and purpose, I should here state that my sole object is to call attention to the importance of the discussion of the more common diseases of women, even to the exclusion of every proceeding worthy the name of operation. In a word, such cases mainly, if not exclusively, as can be properly treated at intervals in our office; as for example, displacements, utero-vaginal inflammation, hyperplastic and cystic conditions of the cervix, endo-cervicitis, endo-, para-, and peri-metritis, subinvolution, inflammation and infiltrations of the pelvic connective tissue, whether of tubal or other origin, and other pathological conditions which need not here be enumerated. First, and above all, let us discuss and carefully weigh the various methods of examination, in order that we may be the better prepared to reach a correct diagnosis and thereby spare our patients much bodily tribulation to say nothing of financial depletion. Let us carefully consider and discuss from time to time the ætiological bearing of constitutional dyscrasias in the production and perpetuation of many of the sexual diseases of women. Let us make known to the physician in general practice that there are other and better means of treating an anæmic, dyspeptic, and habitually constipated woman, who happens to have an eroded and congested cervix floating and bumping in muco-pus, with all the pain, aches, and general wretchedness that such a condition implies, than by swabbing these parts perhaps two or three times a week with some useless or ill-smelling styptic.

I might remark here that it is quite a common occurrence with me, and I presume with others, to meet with cases like that to which I have alluded, patients who are constitutionally depraved

and suffering, of course, from uterine as well as many other troubles in consequence thereof. It is not an uncommon thing for me to dismiss those patients for a month at least, during which time they are put under the proper constitutional treatment. It very often happens that when patients of this class come back for local treatment, I find little or no local treatment called for. I simply refer to this as showing the absurdity of topical applications while the general condition, out of which the local malady originates, primarily and urgently demands attention.

In this matter we may contribute much toward freeing our specialty from the charge of perfunctory routineism, stemming the tidal wave of extreme surgical tendencies, and, to claim for medical gynecology, as the groundwork of scientific practice, some adequate share of recognition. The use and abuse of pessaries also should receive special consideration.

***A Rare Variety of Vicarious Menstruation.***—Dr. Oswiecinski (Weiner medizinische Presse) has observed a rare form of vicarious menstruation, where a female, menstruating first in her eighteenth year, married at the age of twenty-four. After a childless marriage of ten years her husband died. Three months before his death her menses disappeared for the first time, while at the same time a colossal swelling of the right mammary gland appeared in their stead. A large quantity of colostrum could be pressed out. At the same time there were pains in the breast which radiated into the arm. These symptoms lasted for three days and gradually disappeared, to reappear every month in place of the regular menses. The left breast was unaffected. He has observed this peculiar phenomenon six times.

***Technique of Division of the External Os Uteri.***—Dr. Rosner.—Centralblatt für Gynäkologie.—The entire philosophy of this operation consists in opening and keeping open the cervical canal. The opening is not accompanied by any technical difficulty, but maintaining any considerable degree of patency of the external os is accompanied sometimes by almost insurmountable difficulties.

The fresh cut surfaces in bilateral incision of the cervix touch each other and are apt to heal again, causing a narrower canal

than existed before the operation. The use of glass or rubber stems, gauge, suppositories, etc., has not helped the matter much and the operation is in no better credit than in the time of Sims.

To overcome the difficulty Rosner dissects up a narrow tongue or flap of mucous membrane on each side of the cervix, sewing it into and across the angle of the wound to the cervical canal on either side after splitting the cervix nearly three-quarters of an inch. The flaps, which otherwise commence to grow together at the angle of the wound, are held apart by this tongue of mucous membrane, aided by packing with sterile gauze.

Professor Mars has improved on this by first dissecting back a flap or tongue of tissue on each side of the cervix directly over the line of the proposed section of the cervix. After the latter is split the flap naturally falls into the angle between the flaps where it is readily fastened by catgut, without leaving any raw surfaces on the exterior of the cervix to be protected. He recommends that the cervix should be split up to a point midway between the external os and the attachment of the vagina. The operation is performed just after menstruation. A strip of iodoform gauze is placed between the lips of the wound, after the flap is fastened in the angle, and changed every second day for a week or ten days. The flap must come easily to the line of the cervical canal, as it is apt to shrink and become too short to fill the angle.

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## Obstetrics.

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**A Large Fetus.**—Dr. Olano (La Clinique) made an autopsy of a woman dead in childbirth before the expulsion of the infant. The uterus, the fundus of which reached to the liver, contained a fetus, well formed, female, measuring twenty-seven inches in length and weighing twenty-six pounds. He believes that the woman had greatly exceeded the ordinary term of pregnancy, but there was no medical proof of the fact.

**Bringing Down the Foot in Breech Presentation.**—Dr. Achsharumoff (Monats. f. Geburt. u. Gynäk.), acting on the col-

lected opinions of others, has adopted this practice successfully in forty-two of his own cases. Bringing down the foot is a prophylactic measure in breech presentations which has no unfavorable influence on the course of the labor. Indeed, Achscharumoff finds that pains weak before the maneuver become strong after it. The chance of spontaneous delivery of the lower part of the trunk becomes greater, and if the labor lingers the trunk can be all the more easily extracted. The child is more likely to be saved when the foot has been brought down.

**Face Presentation.**—Dr. Dreyer (Norsk Mag. for Lægevidensk) emphasizes the difficulties met with in malrotated face cases. When the chin is to the front no other treatment than that employed in vertex cases will be needed; but when the chin is posterior one should leave the case to nature till, after complete or nearly complete dilatation of the os externum and rupture of the membranes, one recognizes that in spite of good pains the chin does not in an hour or two pass into the pelvic cavity. If, then, there are signs of danger in the lower uterine segment, and if the fetal heart-beats are diminishing in number, and becoming irregular, the time has come for changing the presentation by “redressement.” This treatment is preferred to version, even when immediate delivery is necessary, and he follows it at once by the use of forceps. He thinks there is less danger in applying forceps to the occiput in its high position than in trying version when the lower uterine segment is much distended.

**The Treatment of Heart Diseases during Pregnancy, Labor, and the Puerperal Period.**—Dr. Philips.—Centralblatt für Gynäkologie.—The following varieties of heart diseases may complicate pregnancy:

1. The remains of an old pericarditis and dislocation of the heart in consequence of pleuritic adhesions.
2. Myocarditis and degeneration of the heart muscle.
3. Chronic endocarditis.
4. The recurrent form of acute endocarditis.

If there are no symptoms during pregnancy of insufficiency of the heart, no treatment is required except to regulate the functions of the stomach and bowels, and to avoid climbing stairs.

Disturbances of compensation seldom occur before the fifth month. The therapeutics consist in the use of arsenic, iron, and strychnia for the heart weakness, and of a stimulant for the attacks of faintness and dizziness. If there is œdema and dyspnoea, digitalis or strophanthus, excepting in cases of insufficiency of the aorta.

The dyspnoea is less during labor if the parturient woman sits up in bed. The more severe attacks of suffocation are treated by injections of ether, and often it is necessary to rupture the membranes before the cervix is dilated. The forceps should be applied as soon as the os uteri is sufficiently dilated. Ether is the best for narcosis. A sand-bag should be laid on the abdomen during the extraction of the child, to prevent sudden filling of the abdominal vessels with blood.

The lying-in woman is still in great danger for four days after labor. Post-partum hemorrhage has a favorable rather than an injurious effect, as it relieves the right heart, from which the threatening symptoms arise. Ergot is contra-indicated on this account. Amyl nitrite and subcutaneous injections of ether and strychnia act favorably.

The induction of abortion is opposed in severe cardiac diseases, as it does not prolong the life of the mother, who usually dies soon after the expulsion of the fetus.

***The Induction of Premature Labor and of Abortion by the Intra-uterine Balloon.***—Dr. Stieda.—*Monatsschrift für Geburtshülfe und Gynäkologie.*—A thick Braun's balloon and a modified Barnes-Fehling's metreurynter is thoroughly disinfected with warm water, soap, and a one to one-thousand solution of corrosive sublimate, the air is pressed out, the stopcock turned, and the bags are kept under the sublimate solution. The pregnant woman is prepared by a number of warm vaginal douches and a half-hour's bath of ninety degrees. She is examined internally, and the potency of the cervical canal determined before the introduction of the balloon. The patient is placed on her back across the bed, and the vaginal portion exposed by an anterior and posterior speculum. The anterior lip of the cervix is drawn down with two bullet forceps after it has been cleansed by wads of cotton dipped in a one to one-thousand solution of corrosive

sublimate, and the anterior speculum is then removed. If the cervical canal is large enough, the Braun's balloon is introduced; otherwise the thin metreurynter is used. The empty balloon is rolled together laterally, seized in the dressing forceps and passed up to the cervical canal so that it lies wholly above the internal os, and is held in place until the balloon is filled sufficiently to prevent it from slipping out. This will require over half a liter of sterile water. If there are no pains, after a few hours slight traction on the rubber tube connected with the balloon can be made by fastening it to the end of the bed and elevating the pelvis of the patient. If pains have lasted for some time, traction can be diminished or stopped. If the balloon has partly descended into the cervical canal, which can be ascertained by internal examination, it should be distended with water to the diameter of thirty-five centimeters to secure complete dilatation of the cervix. After the balloon is borne, the further care of labor depends upon the activity of the pains, the size of the os, position of the child, or the presence of complications, such as the prolapse of the cord.

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## PEDIATRICS.

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**A Diagnostic Point in Angina.**—Dr. Massei says (La Clinique) that if a child attacked with sore throat cannot open the mouth, diphtheria may be excluded.

**The Tongue in Rubella.**—Dr. W. R. Lee says the appearance of the tongue in rubella is pathognomonic and describes it as follows: "The tongue is slightly swollen, the edges and sides of the upper surface show a little higher color than normal, the surface is covered to within a quarter of an inch of the edges with a grayish-white, smooth, moist coating; the papillæ are swollen, showing as pink spots through the coating and over the edges of the upper surface. These swollen papillæ spot the whole upper surface of the tongue."

**Infantile Vulvitis a Congenital Disease.**—Dr. Keiffer (Bull. de la Soc. Belge de Gyn. et d'Obstet.) publishes important

observations on the question of vulvar and vaginal discharges in infants and children. He shows that as a part of the process of development an active desquamation goes on in the vagina about the sixth month, and the canal is soon filled with broken-down tissue. The permanent mucous membrane is not thoroughly developed even at term, when desquamation is still in progress. Hence under unfavorable circumstances infection by germs is very easy; a similar incomplete state of the conjunctiva favors ophthalmia in the newborn. The broken down tissue, which fills the fetal vagina, is found in abundance in the discharge of infantile vulvitis, of which it is the cause, having become infected. When not infected it simply escapes through the vulva, without causing any purulent discharge.

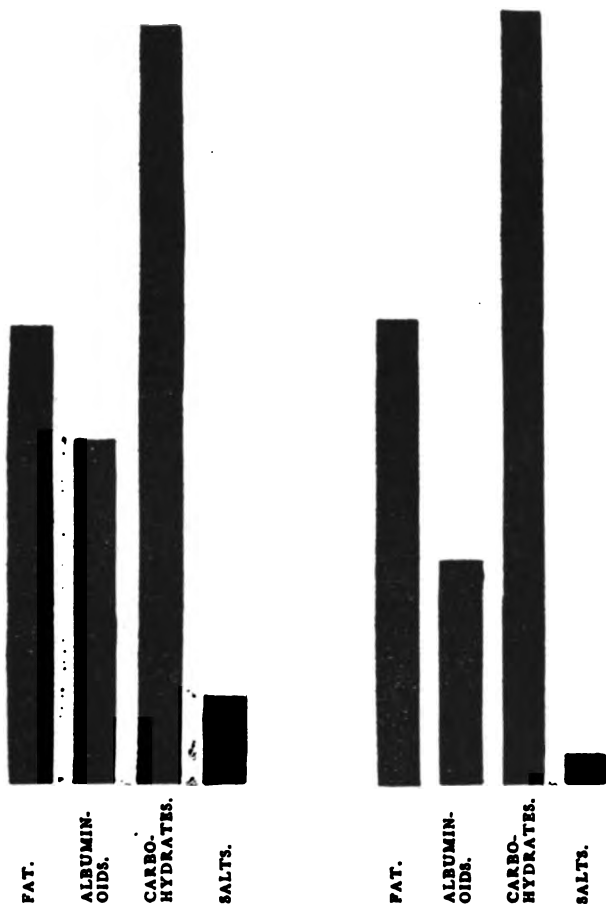
*Helps to Diagnosis in Obscure Cases of Scarlatina.*—Dr. Lindsay.—Among the symptoms most to be relied on are: (a) Initial vomiting, which had been very constant in his experience in children under ten, while it was, on the whole, rare in the diseases likely to be mistaken for scarlatina, such as measles, German measles, and diphtheria. It was a good clinical rule to suspect scarlatina where there was a sudden attack of vomiting with sharp rise of temperature occurring without obvious cause in a young child. Vomiting was less constant in adolescents and adults. (b) Undue frequency of pulse, out of proportion to the other symptoms. A pulse of 140 or 150 was common in scarlatina, and did not necessarily indicate danger. (c) The rash—this was usually scarlet and punctate, beginning on the upper part of the chest, over the clavicles, and about the flexures of the neck. It was often particularly well marked on the backs of the wrists. The face was flushed, and the "circumoral ring" of pallor was usually well marked, but the true scarlatinal rash was certainly very rarely present there. This was a point of great importance, as the rash of measles and German measles usually began, and was particularly marked, upon the face. Great variations of the rash of scarlatina might occasionally be met with. It was sometimes dark-colored and macular, and might even be distinctly papular. Under these circumstances the distinction from measles might be difficult, but the coryza and prodromal fever of measles would usually suffice for a differential diagnosis. Desquamation



was the almost universal rule in scarlatina, but might be absent. He had recently treated two cases in the same room, one of which desquamated and the other did not. Some strange variations from type might sometimes be seen in scarlatina. Thus the disease might be non-febrile throughout, sore throat might be entirely absent, and there might be no perceptible rash. Under these circumstances the diagnosis of scarlatina might be extremely difficult, or even impossible. It was difficult to prove a negative in the case of scarlatina. The disease most often confused with scarlatina was German measles, and so difficult was, in some cases, the distinction that some good authorities still doubted the independent existence of the latter disease. He was in the habit of relying upon the following points to discriminate the two affections: In scarlatina there was usually initial vomiting, which was absent in German measles. In scarlatina the appearance of the rash was preceded by a brief, but usually well-marked, prodromal stage, characterized by vomiting, chill, headache, and sore throat. In German measles the rash was often the first symptom. The rash was always present on the face in German measles, very rarely in scarlatina. In scarlatina the constitutional symptoms were usually fairly well marked, even in mild cases, whereas in German measles it was common for patients to protest that they were perfectly well. The sore throat often went on to ulceration in scarlatina, very rarely (if ever) in German measles. The enlargement of the post-cervical glands was very characteristic of German measles, while it was rare in scarlatina. Attention to these points would often suffice for a diagnosis, but there was a residue of cases in which the distinction between the two affections was practically impossible.

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Fig. XVII—Dorsal Position.

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## MENSTRUATION.

BY HENRY E. BEEBE, M. D.

THE fact has long been established that there is a close relationship between woman's menstrual function and her diseases; especially so, with her pelvic pathology. Permit a quotation from an old book, written about a hundred years ago, by a certain Dr. Hamilton of Edinburgh. He utters about the same ideas as those advanced now, where he says: "It is well known that those women are most healthy who have the periodical discharge most regularly; and, on the contrary, that those who have bad health, either have it excessively, sparingly, irregularly, or want it altogether.

"Hence it has been supposed to be so much connected with health, and so essential to the female constitution, that irregularities of that evacuation prove the source of most of the diseases inclined to the sex. In general, however, these are more frequently the effects of something faulty in the habit than the cause of the bad health which at that time occurs.

"Women in the higher ranks of life and those of a delicate, nervous constitution are subject to sickness, headache, and pains in the back and loins during the periodical evacuation. Those of the lower, inured to exercise and labor, and strangers to those refinements which debilitate the system and interrupt the functions essential to the preservation of life, are seldom observed to suffer at these times, unless from a general indisposition or a diseased state of the womb.

"Women who are nervous and delicate, whose health has been impaired by frequent miscarriages, or whose constitution is weakened by a sedentary inactive life, low diet, or any other cause of debility, are chiefly subject to *immoderate, long continued, or frequent menstruation*. When the blood evacuated, instead of being purely fluid, comes off in large clots or concretions, attended with a considerable degree of pain, throbbing, or bearing down, the case is highly alarming and dangerous, for it indicates a diseased state of the womb, as the discharge, in its natural state, never coagulates."

Now, this ancient citation is yet, in the main, believed to be true, but there are some points pertaining to menstruation which are not so satisfactorily settled, more modern views intruding.

The general anatomy—the study of the apparent properties of an organized body—is usually quite positive knowledge, but its physiology, its precise functions, is sometimes far from being so positive, for varying theories are liable to present, each, aside from the correct one, having some semblance of truth and certainty. From this fact a part of our physiological knowledge is ever changing, and, like some other lines of study, we are obliged to spend much time in unlearning that which we have already learned. Sometimes these innovations are, at first, deemed rank heresy. This is particularly true in our studies of the physiological signification, origin, and function of menstrua-

tion, and in a measure the same with some pathological states, for pathology is but sick physiology.

Menstruation is an involuntary periodic function connected with the female generative organs, mainly the uterus and tubes, whose rhythmical performance is a congestive wave pressure running through the female pelvis, and occurs normally in a cycle of twenty-eight days upon the average. The organs have a time of congestion followed by one of anæmia. Furthermore, menstruation is a manifestation of the organic nervous system and consequently must be under the control of the same—a reflex act originating in the mechanism of the nervous system, and has usually, heretofore, been considered to be a result of ovulation, merely because so often coincident with the liberation of an ovum from a ruptured Graafian follicle in one or both ovaries. The vascular system is affected, the whole arterial system is disturbed, and there is a discharge of blood, mucus, and degenerate epithelium from the uterine cavity, with a general physiological congestion of *all* the organs of generation.

Until about a decade ago it was maintained that menstruation is the result of ovulation, instead of each one being wholly independent of the other, as is now believed by most leading physiologists and gynecologists, through the light of modern anatomical and physiological research. Lawson Tait early claimed that the function of menstruation is seated in the fallopian tubes, and that ovulation and menstruation are wholly independent of each other in the human female. This decided change has taken place in view, mainly from the subject being investigated through the nerve distribution of the abdominal cavity, and the nervous mechanism as supplied to the female generative organs in particular.

Menstruation and ovulation are often used as synonymous terms, or menstruation is often confused with ovulation, through considering that ovulation is the cause. Few



*leading* writers believe to-day that they have any relation whatever, for no reasonable doubt exists now but what the ovary is active before birth and continuously forms Graafian follicles as long as the woman lives, and that during menstrual life probably less than half a dozen ova ripen during the year. All practical experience confirms this fact, and the old idea has been gradually abandoned that the ovary controls the uterus in this function.

It is well established that ovulation is a constant progressive process from before birth until the ovarian tissue gives out. It is not known that it is periodic, so far as we are able to ascertain, like menstruation, or, if it has rhythm, it is not coincident with that of menstruation, but they are totally independent functions—a fair reason why it does not depend upon ovulation. Both are essential to reproduction, and the cessation of either produces sterility.

Dr. Johnstone says: "The only connection between them is that if the four or five ova which form during the year happen to ripen near the end of the menstrual cycle the congestion of the pelvis incident to menstruation so softens the ovary that the follicle is more likely to rupture. Menstruation is only a shedding; it is a process for getting rid of over-ripe material, which is formed for a special purpose, and must be disposed of to make room for newer and stronger material. Nature gets rid of that material, when conception is missed, by the aid of the lymphatics. The endometrium is a lymph tissue. Menstruation washes away ripe and 'rotten ripe' material which was put there for, but has failed to form, a placenta. We know how often menstruation ought to occur, but not so of ovulation. If an ovum is ready to be liberated, at or before the time of menstruation, it is liable to be grasped by the frimbriated extremity of the fallopian tube and carried, wave like, along this canal to the uterus, where a fertile nest is already prepared to receive and nourish it; but if not transported to, and accepted by, its downy couch, it drops into the peritoneal cavity and is absorbed."

The corpus luteum is no more regarded as a positive sign of pregnancy, though such is commonly so. Robinson, says he has found two corpora lutea on the ovary of a lamb, and that he has examined pigs, cows, and sheep, and all ovulated before birth. He has seen ovulation in unborn babes, and in women of seventy.

The fallopian tubes are but a continuation of the uterus. The mucous membrane is the same, and their opening into the peritoneal cavity is the only place in the body where mucous and serous surfaces join. This is the main reason why infection of the peritoneum is so common in women. The nerve supply of the tubes and uterus is very similar; they are the real organs of menstruation, governed, it is believed, by dominating nerve ganglia situated along the walls of the uterus, broad ligaments, and tubes, producing the periodic rhythm or explosion once a month. This wonderful rhythmic phenomenon or function, which rises to the maximum and sinks to the minimum every four weeks, seems to be confined, largely, to the tubes; some contend wholly so, since if all tubal structure be removed menstruation ceases—the menopause is artificially produced after such work; it is not so, sometimes, when fragments of the tubes and broad ligaments are left, and there has been failure to destroy the whole nervous plexus embodied in these parts, when the various pathological reflexes from the uterine region are common complaints.

The chief source of the blood and mucus of the menstrual flow is the uterine mucous membrane, but, instead of the *membrana decidua menstrualis* being a shedding of the entire mucous membrane, it is composed only of superficial layers—the ciliated columnar epithelium of the congested swollen tubular gland structures of the mucosa—whose layers, when torn across, yield the blood. It is merely a shedding of the surface layer of the endometrium.

It has been shown that this function, which takes place in all erect female animals, as well as in the human female—

since it is believed that the erect position is the prime cause of menstruation, and not ovarian influence—is a similar process to the moult in birds, to the dropping of the horns and hair in the deer tribe, and to the shedding of the dermal structures occurring periodically in so many animals. It is too often confused with ovulation and the “rut”—œstrus.

While menstruation and ovulation do accompany each other, are concomitant in the lower animals, they become separate as the scale of life ascends. There is certainly a much more intimate nervous connection of the uterus with the nervous system during the ascending scale of development in all animal life.

While the changed ideas on this subject have come about largely, if not wholly, by the study of this function from the standpoint of the neurologist, it has been brought about more particularly through the investigations of the organic nervous system—the involuntary, automatic mechanism of our being.

The rich mixed nervous apparatus of the female genital organs is interesting and delicate, for it is composed of fibers from both the organic and cerebral systems, and is one of the most complex nervous systems in the body. The external organs, with the vagina and uterine cervix, are supplied by organic nerves, derived from the hypogastric and ovarian plexuses. This nerve distribution is not only to the muscular walls of the uterus, but to the parenchyma of the endometrium and even to its ciliated epithelium. The hypogastric plexus from the uterus can be traced along the aorta to its origin in the solar plexus. Along its course it receives branches from the lumbar ganglia of the lateral chain of the sympathetic. The ovarian plexus is derived from nerve strands from the hypogastric plexus and the lumbar lateral sympathetic chain, and the nerves along the ovarian artery.

Much dispute has arisen over the cervico-uterine ganglion

—the pelvic brain—because the uterus alone is supplied in its neck by cerebro-spinal nerves, third and fourth sacral, largely, while its body proper is furnished almost entirely by organic nerves, and, therefore, the offices of the neck and body are quite different. For this reason the uterus is a rhythmical involuntary organ, while the neck is a still organ, since spinal nerves prohibit rhythm. Many times the sober cervix stands guard and quiets the uneasy rhythmical uterus, prohibiting the expulsion of its contents, as well as not permitting the ingress of foreign invasion. Indeed, uterine innervation is a complex affair.

F. B. Robinson was the first to advance the idea that at the periphery of the hypogastric and ovarian plexuses are located small ganglia along the walls of the uterus and tubes, and, as we have said before, these ganglia govern and rule the periodic rhythm of menstruation, similar to the other visceral ganglia, such as the cardiac, renal, and the ganglia of the digestive tract. He designates these ganglia "Automatic menstrual ganglia," because menstruation is dependent upon this special nervous mechanism, involuntary in its workings.

Well, admitting that such is true, I imagine I hear some one say, "What of it? This is only carrying out a fine spun theory, and can be of but little value to us from a practical point." Now, let us see if this criticism is just, and if the theory cannot be made of practical use in the management of gynecological diseases and hysterical manifestations, as well as in some other functional troubles.

While the utility and independent nature of the organic nervous system, in the animal economy, may not be fully settled in the minds of some few physiologists, because it is intimately blended with cerebro-spinal nerves, we know its functions are rhythmical, and that by it all glandular structure is stimulated and under its control. Besides this, we *do know*, to a certainty, that children have been born at term with no cerebro-spinal axis, and that they live

with many or most of their physiological functions being fully carried out, performed under a natural law, and independent of the cerebro-spinal system. We furthermore know the part of the so-called sympathetic nerve which appears to be *most* independent of the cerebro-spinal axis, is that supplying the generative organs and the digestive tract. The important dominating influence of the sexual instinct throughout the whole animal kingdom over the physical being is also equally well understood and appreciated by the physician.

While the solar plexus—the great abdominal brain—is endowed with the high powers and phenomena of a leading nerve center, governing the abdominal and pelvic viscera as a whole, special organs have sub-plexuses, relay cells, small nervous ganglia scattered through the viscera which serve as little brains of their own, controlling their special rhythmical functions. These peripheral ganglia, or nervous bulbs, are capable of developing or diminishing nerve force and communicating it to the organs, without the aid of the cerebro-spinal axis. It is through these distal or terminal automatic visceral ganglia that the liver secretes bile, the stomach gastric juice, the rest of the alimentary canal its fluids, the kidneys perform their important function, each through its own special individual ganglia, or little brains, directing and reorganizing the work, through the solar plexus mainly. These forces are involuntary, beyond the control of man's mind—the will. These ganglia receive sensation, send out motion, control secretion.

Disease of any of these visceral organs or the disturbance of their rhythm must be commonly due to some abnormal force disturbing their functions, and arising from the organic nerve centers, oftenest the great solar plexus. Disease may be more easily diagnosed by a study of the working of the special ganglia of the organ under investigation. This is undoubtedly true with our studies of uterine disease.

From trustworthy investigation, made by competent workers in this important field of research, aside from Robinson, it is shown that the uterus and tubes do contain in their walls special ganglia, believed now to control menstruation through a law and giving the regular monthly rhythmical function common to all healthy women during menstrual life. This, and not the epithelial structure of the ovary, is the source of the menstrual wave cycle—the so-called Stephenson wave.

The disturbance of this physiological law, thereby causing disease, is common at its commencement—puberty—or at its cessation—the menopause. The menstrual rhythm is not always perfectly initiated, nor sustained at its inception, and pathology succeeds in supplanting physiology, manifest often by pain, irregularity, or the quantity of the discharge is not normal.

The girl who reaches puberty early is most subject to profuse menstruation, and more liable to suffer from chlorosis and menstrual disorders. The girl who begins late is likely to possess a weak, nervous system, suffer from dysmenorrhea, and possibly sterility. The first suffers from precocious genital development, accompanied by other evidences of premature sexual maturity—the premature development of the whole organism concurrently with menstruation. The second class, those girls whose menstrual function is late in being established, is due to deficient development or low constitutional conditions; they, too, have other manifestations of this weakness. The fleshy maiden, as well as the tubercular girl or one where there is any systemic cause producing a profound impression on the constitution, is liable to irregular menstruation, due to the equilibrium of the wave pressure not being well established. The menopause is characterized by reflex disturbances, commonly implicating the nervous centers, the vasomotor center in particular with it, the nerve forces are suddenly shut off, and other nerve

reflexes follow, chiefly from atrophy of the hypogastric plexus, and markedly so with the uterine and ovarian plexuses. Here the neurotic manifestation is very unstable and quite apparent. Anæmia causes as much trouble as hyperæmia, and should be equally regarded, though it is not often so considered.

Functional disturbance, or the clinical importance of the menstrual wave, is not sufficiently appreciated by the clinician, and I certainly believe not nearly as much so as it will be in the near future, for it is a symptom of disease and there are few functionating organs in the body not liable to be deranged by disturbance of this wave. Most of us recognize that menstrual neuroses are very common. These manifestations are most liable during the crest of the wave—the congestive part—but not always there, for sometimes it is the anæmic condition that the system most resents, shown by the intermenstrual pain and other abnormal symptoms.

Rhythm is the physiological function of the organic nervous system. This special nervous mechanism only possesses this property, which is present in all viscera, and if the rhythm in one organ be disturbed most of the other viscera share in the trouble, and we have disease from reflex action.

While the great solar plexus is the leading center and governor of this rhythmical power in the visceral cavities, organizing, multiplying, and diminishing nerve forces, there are sub or relay stations throughout the periphery of this great center. There is a special mechanism in each viscus, not only sending orders to the solar plexus, but modifying the duties, as well as doing some independent work for the special organ of its choice. This applies particularly to the viscera of the abdomen, but the organs inclosed in the chest and cranial cavity are far from being exempt.

The extensive supply of these special nerve ganglia in the uterus, it having a greater stock of these organic nerves

than any of the other viscera, is connected with the solar plexus by twenty or thirty strong nerve strands; therefore, we expect a greater number of neuroses from pathological conditions arising in it.

Now, while the solar plexus is the great nerve center of organic life, the uterine and tubal supply is the distinct nutritive center for the basic generative organs—the independent center for the menstrual function—the most important physiological office woman has to perform. If these intricate and dependent parts, so liberally supplied with organic nerves, be disturbed, or are out of repair, the menstrual rhythm, the Stephenson wave, is commonly altered, and, as a result of this peripheral nerve apparatus, whose essential pathology is reflex action, the rhythm of other visceral organs is disturbed. Why should not a condition which nags the nervous system provoke a condition of revolt? The manifestation may be shown in the chylipoetic system, the liver, the stomach, the lower alimentary canal, by indigestion, the respirative organs by dyspnoea, and in the heart—cardiac rhythm being frequently affected—or the brain, headaches being so very common. That organ which is the weakest and offers least resistance complains first. In fact, any or almost all the associated visceral organs are liable to suffer. A perfect physical condition is at least impaired. Organic troubles may and do often result if the irritation be of sufficiently long duration.

The transmission of reflexes—a very indefinite term—from diseased viscera, is no small study, and to the gynecologist this line of pathological influence, which may be found in the most unexpected places, is worthy of close and careful investigation. If other organs of less consequence have their automatic functional ganglia, certainly so important a one as the uterus, with its overly rich nerve supply, should have the same, when its healthy function is so very necessary to all well-formed women, and its going wrong



must give us a clew to the diagnosis of their diseases. Disordered menstruation, when positively associated with the menstrual rhythm or disturbance of the menstrual wave in any part of its course, is the key—the landmark—to the diagnosis and cure of many of woman's distresses, when properly viewed and traced to its real source. The belief is growing with those who are keeping abreast of the literature of gynecology, that menstruation depends more upon the nervous system and general health—the nutritive forces—than anything else, and that we should treat the patient more and the disease less. The earnest student who investigates this question thoroughly from this point will confirm such conclusions: that a diseased uterus commonly has its monthly rhythm disturbed, and through it the rhythm of other visceral organs is deranged, all of which impair the general health of the patient. No doubt many of the higher physiological actions originate in the solar plexus, or, if not started here, this abdominal brain has a wonderful influence over them. Here, nerve force is received and reorganized, to be sent out in different directions, and through it the breaking of the rhythm of one viscus may take place, thereby disturbing the functions of all, or a part, of the rest of the body's organs. This is in no organ so significant as in the uterus.

Certainly the automatic—involuntary—part of our being is entirely too little studied. This is a field for more careful cultivation. To the general practitioner it is fully as important as that of any other specialty, and without it we cannot always intelligently practice gynecology. May this line of thought continue to be investigated in earnest by all interested in re-establishing woman's healthy physiological function—her moral rhythmical cycle—menstruation.

## EARLY SECONDARY REPAIR OF THE PERINEUM.

BY ABNER H. POWERS, M. D.

THERE are few Americans in the medical profession who are anxious to argue against the repair of the perineum at the time of the accident. The success of the primary operation is favored by the paralysis of the perineal muscles from overstretching at child-birth, and for a few following days there is no force drawing away from the laceration, and sutures applied even indifferently will often prove sufficient to hold the torn surfaces in contact till healing has occurred. This is the result we strive and hope for and in most cases it may be attained, but there are cases where from some known or unknown cause primary healing does not take place. This may occur from the positive refusal of both husband and wife to allow sutures to be introduced, or there may be a fear of flooding and the patient refuses to have the sutures applied without an anæsthetic, which would render hemorrhage more probable. In fact there may be septic infection of the wound, and this from known or unknown causes, and this usually prevents healing.

What shall be our advice when from any cause primary union has failed to occur? The usual course followed, so far as I am able to judge, is that the woman is told of the failure and advised to have a secondary trial in six to eight months.

Now by the sixth to the eighth day if there is failure it may be known, and the woman is not as yet in a fit condition to get up, but must remain in bed for a week or more before she will be advised to go about. It has occurred to me that this time would best be utilized in securing the needed repair of the perineum, and at most only three to five extra days will be required to give success. Some of the reasons for the operation at this time are :

First. Few women will appeal to the surgeon for an operation till she has suffered for a variable time, and often the discomfort has come to be unbearable and without aid the woman is a chronic invalid. Still further, the discomfort may not be so great and the fear of an operation will postpone the relief indefinitely.

Second. The involution of the uterus and vagina will be retarded or hindered, or subinvolution will occur more frequently if this repair of the perineum is delayed than if it occurs at once, and hence a longer period of convalescence than normal will prove necessary.

Third. All the pains and aches which the woman may have before the repair of the perineum will be associated with that tear, and she will expect them to vanish as by magic when this lesion is properly healed, and I hardly need say that so gratifying a result does not always follow even the most successful operation. An additional reason why operation should be performed at this early date is found in the fact that the woman is accustomed to the bed, and hence does not feel as severely as later the confinement in bed which follows.

One reason already given for this early operation applies with equal force to those cases where there is subinvolution and some weeks have elapsed since child-birth. Here immediate operation is especially necessary to give the best opportunity for nature to complete the process which has been interfered with. In all cases where the perineum is torn there can be no doubt but perfect repair at an early period lessens the probability of uterine disturbance.

In regard to the manner of operating, I would say a few words. The bowels should be well emptied and the genitals and surrounding area made aseptic by bathing. An enema is usually sufficient to free the bowels if skillfully employed. Then the patient, fasting, as is usual for anæsthesia, is etherized and with a curette the granulations are *all* removed and firm healthy tissue is reached. This done, the

denuded surfaces are carefully approximated by three or more deep silk or silkworm-gut sutures, and by fine catgut the tear of the mucous membrane and the cutaneous surface is closed by a continuous suture. This must be done more carefully than in the primary operation, since the perineal muscles have regained their tone and tend to draw the surfaces apart. The wound is then treated as is usual in these cases, and at the expiration of ten to twelve days the parts will have so healed that the stay sutures may be removed.

Now a few words in regard to the contra-indications for the operation, and I have done. Of course, the operation should not be undertaken on a patient suffering from cancer of the genitals or in case of far advanced tuberculosis of the lungs. These and similar conditions are a law unto themselves. The special contra-indication is sepsis. This is especially the case where the uterus or appendages are involved and a discharge of pus flowing over the wound must be expected. If the sepsis is not of an active type and is confined to the granulating surface it is possible to so cleanse the parts after the curetting by the use of antiseptics that healing may occur, but it is not well to promise unconditional success. The danger other than from supuration of the wound is that the tissues, softened by the inflammation, may allow the sutures to cut through before healing has been accomplished, and thus failure occur from a separation of the parts.

To emphasize the points I would recapitulate. If a primary operation fails, or from any cause the tear is unhealed six to eight days after child-birth, secondary operation should be most carefully performed to avoid the various ills which follow neglected tears of this structure. Rather than allow months or years to go by before any secondary operation is made, these operations should be performed early to avoid suffering.

## MALFORMATION OF LOWER ORIFICES.

By J. J. THOMPSON, M. D.

**M**ALFORMATIONS of the lower orifices are either congenital or acquired. In this paper we shall discuss only the congenital variety, and, in order to understand these malformations thoroughly, it becomes necessary to know something of the development of the parts.

The student of embryology is aware that in the beginning of fetal life the central portion of the alimentary tract consists of a simple tube which ends at either extremity in a blind sac. This tube, which is called the mesenteron, is made up of hypoblast, and goes to form the mucous membrane. Later, this tube of hypoblast becomes enveloped in a covering of mesoblast, from which the peritoneum and muscular coats of the intestinal tract are formed.

Our throat and nose specialists tell us that the mouth and nares are formed by an invagination of the epiblastic layer to meet the anterior or upper portion of the mesenteron. This invagination at the upper extremity is called the stomodeon, and any defect in its development will cause deformity of the mouth or nares. In the same manner the lower orifices are formed by an invagination of the epiblast to meet the lower end of the alimentary tube. This lower invagination is called the proctodeum, from which the anus and generative organs are developed. At first these orifices are not separated, but form a cloacal opening. At about the eighth week of fetal life the anus is formed and closed off from this cloacal opening. At about the same time the rudiments of the perineum can be detected, and the vagina and urinary tract become separated, making the three passages separate and distinct.

The anal depression continues to grow upward, as it were, to meet the alimentary tube, while the tube devel-

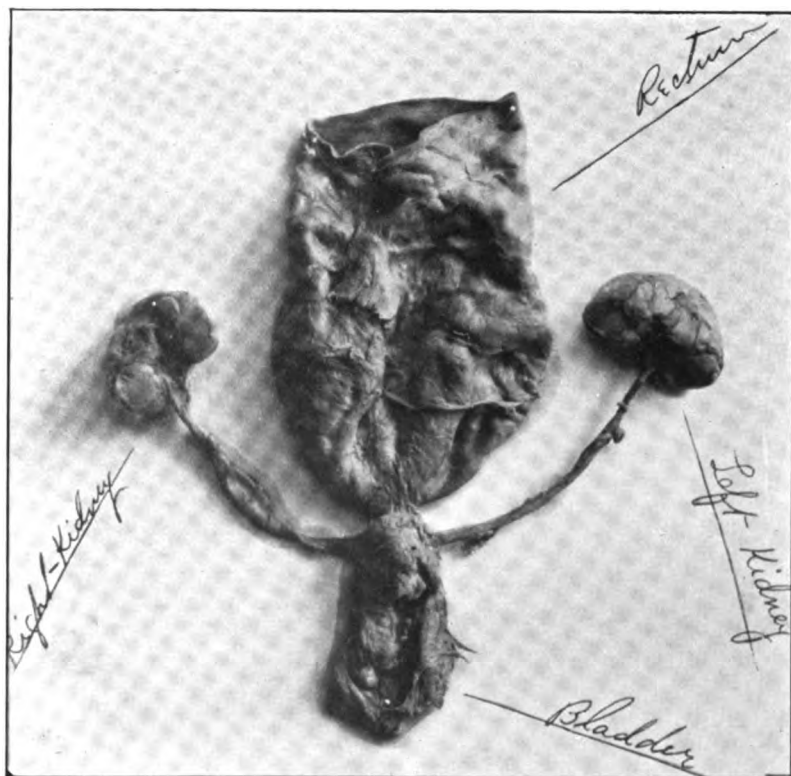


FIG. 1.



ops downward to meet the proctodeum until they meet, and the canal becomes patent.

Most malformations of the rectum and anus, as well as the vagina, are the result of arrested or pernicious development of the proctodeum or of the mesenteron.

In all malformations of the lower orifices the general tendency is for the intestinal canal to open into the genito-urinary tract, or *vice versa*.

Malformations of the lower orifices, then, may be divided into four general varieties.

1st. Where the canal ends in a blind sac or is entirely obliterated.

2d. Where the alimentary canal opens into some portion of the genito-urinary tract.

3d. Where the genital or urinary canals open into the rectum.

4th. Where one or more of the lower orifices open externally at some point more or less distant from their normal site.

Each of these classes might be further divided and subdivided, according as treated by gynecologists, the genito-urinary surgeon, or the rectal specialist. It is not my purpose, however, to enter into a further classification of the subject, but I desire to bring to your notice some of the cases which have come under my observation and the method in which they were treated.

The first case which came under my notice I saw in connection with Dr. M. M. Thompson, and it is through his courtesy that I was enabled to photograph the specimen which I will now show you. This was a male child born without any anus, the perineum being entirely smooth. We undertook to dissect up through the tissues of the lower end of the intestinal tube, but failed to reach it, although we made the incision as deep as could be safely done. A day or two later, however, the child began passing fæces with the urine, and continued to take nour-



ishment, and lived three weeks. The parents refused to have a laparotomy performed for its relief. A *post-mortem* examination revealed an entire absence of rectum, a small tube connecting directly from the descending colon to the bladder, as shown by the illustration (Fig. 1). A deep *cul-de-sac* at the trigone of the bladder shows nature's effort to return to the rectal canal.

Another case which came under my notice was that of a girl about twelve years of age, who was born with an imperforate anus, but there being a bulging of meconium into the vagina, her physician made an opening through the recto-vaginal septum, thereby producing an artificial anus, which answered the purpose very well until she approached maturity, when her parents desired an operation for her relief. The surgical work was done at two separate sittings. The first consisted of an opening through the perineum up to the lower end of the gut. It being necessary to cut through perhaps an inch of tissues, in doing so a blind sac was opened posterior to the lower part of the rectum, which contained a collection of a white cheesy substance resembling smegma.

At a later sitting the opening into the vagina was closed by a plastic operation.

One of the most interesting cases which I have ever seen was one referred to me by Dr. J. H. S. Johnson of this city. This patient was a young lady of nineteen, of perfect form and general good health, but she was born without an anus, the rectum terminating in the vagina just above the fourchette.

The action of the vulvo-vaginal sphincter was not good when the bowels were loose, but fortunately, perhaps, for her, the bowels did not move oftener than once in three or four weeks, although the patient seemed possessed of an ordinarily good appetite. The wonder was, as her mother expressed it, what became of all she ate. About once in four weeks the patient would be taken with severe cramps



FIG. 2.—PREPARED FOR OPERATION.



throughout the abdomen, which would be accompanied and followed with a profuse diarrhea, lasting for three or four days, after which the bowels would be locked up again for another month. When I first examined her I found a large, hard tumor a little to the left of the median line, which extended well up into the abdomen. My first thought was that this was a fibroid, but when I learned that the bowels had not moved for nearly a month I readily suspected that the tumor was an impacted fecal mass, as was demonstrated when the rectum was thoroughly cleaned out, which, by the way, was no small task. The accompanying cut (Fig. 2) shows the condition of the parts as prepared for operation.

The bowels having been thoroughly evacuated, the operation performed was that recommended by Rizzoli, which consists in making an incision from the fourchette directly backward to the tip of the coccyx. The lower portion of the rectum, together with the vaginal anus, were then dissected out, care being exercised not to cut into the bowel. The rectum was then brought down, and what was formerly the vaginal anus was stitched to the lower angle of the incision. The edges of the wound in front of the rectum were then sewed together with deep sutures, the same as in an ordinary case of lacerated perineum. This entirely shut off all connection of the bowel with the vagina. Fig. 3 shows the completed operation. In this case the wound healed perfectly by first intention, and the patient now passes the fæces every day through a normal anus, the external sphincter behaving very creditably considering the lack of exercise which it has had for the past nineteen years. In this case the levator ani muscles were in good condition, and the external sphincter muscles, which it will be remembered are little more than two bands of muscular tissue extending from the tip of the coccyx to the central tendinous point of the perineum, were fairly well developed.

Another interesting case of congenital malformation was one sent me by Dr. A. E. Auringer of McHenry, Ill. This case had been diagnosed as one of absence of uterus with the tubes opening into the vault of the vagina, and on the first inspection I quite agreed with this diagnosis. But upon inserting the finger of one hand into the rectum and pressing down upon the abdomen with the other hand I was able to outline a normal uterus. I then passed a small bent probe through one of the openings into the vagina and was able to bring it out through the other opening. Using this probe as a guide I then incised the septum from one opening to the other, and was surprised to find an upper chamber to the vagina filled with the tarry products of her last menstruation. Having douched away this debris, the cervix uteri was found to be in a normal condition. The attachments of the septum were then severed from the vagina with scissors and the vagina packed with gauze. Ten days later the patient was sent home a normal and very happy woman.

Another case of congenital malformation which was of special interest was seen about two years ago with the late Dr. O. F. Baines. This was a case of complete atresia of the vagina. Laparotomy was performed in order to determine the condition of the internal congenital organs before trying to establish a vagina. The uterus was found to be very small, about the size of one's little finger. The ovary of the right side was absent, and the tube of that side was rudimentary. On the left side the ovary was fairly well developed, and, if I remember rightly, showed signs of ovulation, but the tube on this side was only partially developed, although the fimbriated extremity was nearly of normal size.

It was decided to remove the ovary and tube, as there was considerable pain at every attempt at menstruation, which effort occurred at regular intervals.

No attempt was made at this sitting to establish a



FIG. 3.—COMPLETED OPERATION.



vagina, but it was decided to do so at a future time. After the death of Dr. Baines the case fell into the hands of another physician, who I understand succeeded in establishing a fairly good vagina.

Other cases of faulty development of the vagina, hymen, and vulva have come under my care, but they were not of sufficient rarity to need mention here.

Of congenital malformations of the urethra the most common forms in both sexes are hypospadias, epispadias, and exstrophy of the bladder, mentioned in the order of their frequency. These deformities are much more common in males than in females. Several cases of hypospadias have come under my care. In Dr. Frank's clinic in Vienna some years ago I witnessed a method of repair for hypospadias which was both unique and satisfactory. I have since had occasion to try it with flattering success. One patient upon whom I operated had undergone several unsuccessful operations for the relief of his trouble until there was little remaining tissue which could be utilized about the urethral opening. This opening was about an inch posterior to its normal site. Anterior to this opening the urethra was again normal.

I first made two longitudinal incisions on either side of the orifice, each incision being about half an inch long and about a fourth of an inch from the edges of the opening. I then dissected the flaps toward the opening and, bringing them over, stitched their edges together with fine cat gut, leaving their raw surfaces upward. I then detached and slid together another flap from each side in such manner that the raw surfaces of these second flaps lay upon and covered the raw surfaces of the first flaps. This gave a double wall, with two rows of sutures, the outer row being of fine silk. The work was done with cocaine anæsthesia in my office and was quite a contrast in the mind of the patient to the unsuccessful efforts which had previously been made with the patient under chloroform anæsthesia.

In many cases it first becomes necessary to establish an



opening through the glans penis before closing up the abnormal opening.

Epispadia is usually accompanied with exstrophy of the bladder, whether it occurs in male or female.

A case was reported to me recently by one of our students, who was called to nurse it, which from his description was a case of exstrophy of the bladder with epispadias. This case was a man whose ureters opened upon the abdomen just above the pubic region. The anterior portion of the bladder being apparently absent. The man had been able to hide his deformity by wearing a sponge pad over the openings of the ureters, and had enjoyed comparative health until just prior to his death, which occurred recently at about forty years of age.

These cases are very rare and seldom live to maturity. Undoubtedly his condition could have been greatly benefited by a plastic operation, which would have consisted in building up an anterior wall to the bladder from the surrounding tissues.

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## TUBERCULOSIS OF THE ABDOMEN IN CHILDREN.\*

BY JOHN ROBERSON DAY, M. D., London.

THE subject of this paper was suggested by several cases which have recently come under my care both in hospital and private practice. These cases presented the greatest variety in appearances, general course, and duration; in fact, were it not for our present knowledge of pathology, it would be difficult to see what connection there could be between such a heterogeneous assortment of diseases; take, for instance, ascites and tabes mesenterica; but we know there is a common bond of union, and the *fons et origo mali* is in all cases the same.

\* Read before the British Homeopathic Congress, Bristol, September 16, 1897.

This morning we had the advantage of hearing a good deal about micro-organisms and the part they play in relation to disease. It is impossible to overestimate the importance of this subject and the light it throws on disease. There is very good reason to believe that all tubercular lesions are characterized at one time or another by the presence of a constant micro-organism—the bacillus tuberculosis. This has been found in the sputum of phthisical patients, in the lymphatic glands of strumous subjects, in cases of caries of bone and white swelling of joints, and, as I can show you, in a specimen of the bacillus under the microscope taken from the suppurating retro-peritoneal glands of Violet G., whose case I shall have more to say about presently.

Here, then, the unity of this apparently many-sided disease is evident.

My remarks will be limited to the *abdominal* lesions of tuberculosis. These frequently coexist with the same pathological processes elsewhere, although this is not necessarily the case. These abdominal lesions are very characteristic and important.

There are certain varieties which I have tabulated in the syllabus, but all these forms are liable to merge the one into the other, or the same patient may at one time be affected with one variety and subsequently develop another.

The commonest met with is the *intestinal*. One constant symptom is chronic diarrhea, and this soon leads to marked wasting. In the children of the poor this is an extremely common disease, and the causes are not far to seek. Born of enfeebled and debilitated parents, who through poverty and ignorance are unable to provide a suitable diet for their children, gastric troubles are early induced in them. A catarrh of the gastro-intestinal mucous membrane is thus set up, and in time ulceration follows. Let me illustrate these remarks from Case I. Wm. C., aged 5½, was born of unhealthy parents; the

father is a diabetic, the mother was operated on in the gynecological department of the hospital for what proved to be a form of malignant disease. The fact that his father had diabetes is responsible for a good many of this boy's troubles. The inordinate appetite of the father led to constant eating; food was always about, and this little fellow was always eating improper food, a practice which sooner than anything else leads to gastro-intestinal catarrh and its invariable symptom—diarrhea—from which he suffered two or three years. Very soon ulceration of the intestine follows, and the nearest lymphatic glands become irritated, and the case merges into one of the next variety, the *mesenteric disease*, or *tabes mesenterica*, as it is usually called. This stage is characterized by considerable enlargement of the abdomen, and in some cases it is possible to make out by deep palpation the masses of enlarged lymphatic glands. Wm C., whose photograph I have here, exhibits this condition in a marked degree. There is another constant symptom. Accompanying the diarrhea is a very fetid odor, which is almost characteristic of the disease. It is very penetrating, and causes the child even to smell, no matter how clean he may be kept.

I have spoken of the emaciation of these cases, which sets in early, and is often very marked, accompanied with prominent veins marbling the surface of the face, chest, and abdomen.

The skin also is dry and harsh, rarely perspires unless there is co-existing rachitis, when there may be profuse perspirations about the head and neck.

Such are the general characteristic of *tabes mesenterica*.

The third variety, the *peritoneal*, differs considerably from the two former. In this instance, the brunt of the disease falls on the peritoneum, and there are two varieties, (a) where ascitic fluid is poured out, often rapidly and in large quantity; and (b) where tubercular deposits take place, which may produce a localized tumor or lead to a

general matting and binding together of the intestines and abdominal organs. This is a form of great interest, not only for the difficulties which at times beset the diagnosis, but also on account of the mysterious way in which recovery has been known to follow a simple exploratory abdominal incision.

I propose now to read you extracts from the notes of five cases which have formed the chief basis of this paper.

*Intestinal and Mesenteric Forms.*

CASE I. *Tabes mesenterica*. Wm. C., age 5½. Past personal history: Father has diabetes. Mother, malignant disease of the peritoneum. Eight other healthy children.

History of present illness: Never been very strong, and his father, a diabetic, always hungry, constantly fed him on improper food; this, his mother thinks, was the first cause of the disease. The bowels have been loose and offensive for two or three years.

Present condition on admission, February 29, 1896: Has a large pendulous belly; much flatulent distention; no masses are to be felt; no free fluid in the abdomen; has pain at the umbilicus when the bowels act; heart and lungs normal. *Ars. iod.* 3x gr. *ji. ter die*. This was changed to *ars. iod.* 3 on March 16, and on March 29 *ars. iod.* 3x was resumed. The notes state a steady improvement. The motions less frequent and lost their offensive odor, and the abdomen became less tense.

April 2. Sea-water sponging was ordered, and on April 26 sulph. 30 *m* *ii. ter die* given. May 6. Left the hospital.

In addition to this treatment, while in the hospital I had the bowels irrigated with a weak solution of boro-glyceride, and I am sure this was attended with great benefit; it washed away the fetid motions, and thus lessened the danger of auto-infection, which is a real danger in many diseases where the bowels are not acting normally.

CASE II. *Tabes mesenterica*. Family history: Mother, a Canadian, delicate constitution. Father, a Belgian, a strong, powerful man; one other boy, strong. Pauline de G. R., age seven, was a fine baby at birth and was nursed at the breast till four to five months, after which she was bottle-fed. At ten months she had influenza and was constantly sick. With teething diarrhea began, and at twelve months had constant offensive diarrhea six times a day, no appetite, and gradually got worse, with great belly, and could count her bones. She continued under allopathic treatment till two years old, when she was taken to Brussels and saw a homeopathic physician there (Dr. Gailliard). He, on their return, referred the parents to Dr. Hughes, who kindly sent the patient to me. When I first saw her she was pale, thin, and very delicate-looking, with very scanty thin hair; the skin was dry and had an earthy tint. The veins marbled the forehead. She had a very large abdomen, was very listless, with poor appetite and constant offensive diarrhea. The tongue was always mapped and very pale. I at once most carefully dieted her, but it was difficult to get her to take milk. Raw meat juice and Valentine's juice were given in gradually increasing doses. The principal medicines were iodine 3, ars. iod. 3 and 3x, calc. iod. 3x, sulph. iod. 3, chin. ars. 3x. She is now an absolutely different being. Her hair has grown thick, color has come to her cheeks, the tongue is no longer mapped, there is no longer any diarrhea, and the abdomen is now normal in size. She is lively and skips about and walks well. At one time in her illness I used massage and inunctions of cod-liver oil, with the greatest benefit; at that time she suffered from great flabbiness of the muscles and relaxation of the ligaments. This was causing flat foot and its consequence—knock knee. By carefully regulated tiptoe exercises this condition was cured and the result of treatment in her case most satisfactory.

I should say the treatment extended over a period of

some years, but in so serious a disease considerable time, care, and attention are necessary to effect a complete cure, and this is the reason why the children of the poor who suffer from this disease very often go from bad to worse, because it is impossible to give them the long-continued care and good feeding which are necessary to bring about a cure.

*Peritoneal Forms.*

CASE III. Ascites. Rosa S., age fifteen months. Admitted to the hospital December 31, 1896.

Family history: Father, age twenty-four. Mother, age twenty-four. Both healthy. The mother had chorea three times before marriage, and a maternal aunt died of phthisis. This patient is an only child, has been bottle-fed since birth with cow's milk and barley water. Has *five* teeth.

History of the present illness: Since three months has been getting big in the abdomen. Screams at night and draws the legs up.

Present condition (December 31, 1896): There is great distention of the abdomen; the circumference at the umbilicus measures twenty-one inches. The abdomen is dull on percussion, and the skin tense and shiny and gives a marked thrill. The umbilicus is everted and projecting, tense and shiny. The bowels act regularly two to three times a day. Owing to the screaming of the child a complete examination was not possible. *Apis 3x ter die.*

January 4, 1897. Patient seen again and admitted to Barton Ward. The rest and treatment (*apis 3x*) quickly reduced the fluid and the child was discharged, to attend as an out-patient.

January 28. The inguinal glands were observed enlarged and calc. *iod. 3 given ter die*, also bovine.

On February 4 there was great improvement, but the proximal phalanx of the right little finger became enlarged,

with strumous dactylitis. Ars. iod. 3 g. ij. ter in die ol. morrh.

On February 11 calc. c. 6 was given.

March 11. A purulent nasal discharge appeared, with ulceration of the upper lip. Merc. sol. 3x ter in die. The general condition much improved, and ars. i. 3 was again given and is still being taken.

This, gentlemen, is a case in illustration of the ascitic form cured by treatment.

CASE IV. This case is of exceptional interest. The patient first came with the ascitic form, which was cured. Then she developed tubercular adenitis, and the inguinal glands on both sides suppurated. Finally she came with white swelling of a knee and elbow.

Tubercular Peritonitis.—Lucy L., aged twelve, admitted to London Homeopathic Hospital, September 20, 1895.

Family history: Good.

Past personal history: Eighteen months ago in London Homeopathic Hospital with same complaint. At that time there was ascites, but no hard masses in abdomen. Ars. iod. 3 and 3x rapidly cured her.

History of present illness: Ailing for last six months; getting thinner, paler; loss of appetite; bowels costive.

On admission: Weight, 6 st. 11 lbs. Temp. 101.4° in evening; fairly well nourished; sallow complexion; abdomen generally slightly distended; on palpation a doughy feeling; in left iliac fossa is a well-defined hard fixed mass, size of hen's egg, tender to touch, slightly resonant on percussion; in right iliac fossa is a fullness, but no distinct swelling. Calc. c. 3.

September 25. Since admission the mass above mentioned has become smaller. Occasionally a griping pain in the abdomen, not worse at any particular time. Patient lies on the back, as a rule, with the legs drawn up. Temp. rises to 101.8° at night, profuse perspirations every morning. Tongue cleaner. Bowels only open with enemata.

October 3. Temp. has risen to 102° for the last five nights; night sweats. There is an obscure fluctuating feeling over the mass in the left iliac fossa. Within the last three days a distinct swelling has appeared in the right iliac region, and there has been pain in that region.

October 5. Two or three enlarged glands in the posterior triangle of the neck slightly tender, but no acute inflammation.

October 14. Temp. at night 100–101°; normal or sub-normal in the morning.

On October 29 she was discharged.

The treatment had been calc. carb. 3 for a short time, but principally, and nearly the whole time, iod. ars. 3x.

Subsequently these glandular masses in the groin suppurated and discharged, and have left deep scars. Then she came under treatment for tubercular swelling of one knee and an elbow. The tubercular disease, having left the abdomen, manifested itself elsewhere. She continued as an out-patient for a long time and is now quite well.

The treatment was principally with the iodide of arsenic.

CASE V.—And this is the last one with which I will tax your patience, illustrating the last variety of the disease: the peritoneal form with tubercular deposit.

Violet G., age thirteen.

Family history: Admitted March 18, 1897. Father living, well; mother living, well; two brothers and two sisters living. No history of consumption in the family. Patient has had whooping cough, measles, and scarlet fever last August; usually enjoys good health, but has never been very strong. For the last three months has suffered from gradually increasing weakness and pain all over the abdomen, attributed to indigestion. Appetite has been very bad. She has been thirsty, and for past six weeks has had diarrhea, two stools a day—loose, dark, and offensive. Before this she was constipated. Has been losing flesh considerably for the last two months. No cough, no



night sweats, no shivering fits. During the illness has passed water more frequently than before, often three times in the night. Menses have not appeared. For the last week a swelling has been noticed in the lower part of the right side of the abdomen; it is not painful or tender.

Present condition.—Patient is a delicate-looking girl, with a hectic flush, and poorly nourished.

Tongue.—Moist, thin coat of white fur. Appetite bad.

Bowels.—Moderate diarrhea.

T. 99° on admission. P. 120; regular, soft, small.

Chest.—Nothing abnormal.

Back.—Nothing abnormal.

Abdomen.—Rather distended. The right side a little more prominent than the left.

On palpation the abdominal walls are found to be much more rigid on the right side than the left. There is the feeling of a deep-seated resistance all over the right half of the abdomen, but in the iliac region the resistance is more marked and quite superficial. Fluctuation not obtained, slightly tender.

In the outer part of the right iliac fossa there is an elliptical area of dullness (about 4 in. by 3 in.), which corresponds with the area of superficial resistance.

Urine: Clear; sp. gr. 1015. Alkaline, slightly ammoniacal. Opaque white deposit of amorphous phosphates and triple-phosphates. No albumin or pus.

March 25.—Temp. last night 102.4°, this morning 101.2°. The area of dullness seems to be rather more extensive, especially at the upper part. Gets occasional sharp, shooting pains in the region of the swelling. Was sick once last night. Bowels opened once on 22d, twice on 23d; stools partly formed; no other action of bowels since admission. Taking bell. 3, hep. s. 6. alt. 2 hours.

March 29. Was examined under an anæsthetic, and the above observation as to the swelling confirmed.

March 30. Bry. 1x, calc. c. 3x, alt. 2 hours.

April 1. Abdomen in general is rather more distended; limits of the swelling are not quite so defined and dullness is less complete; very little pain.

April 2. Bell. 1x, nux. v. 3x, alt. 2 hours.

April 5. Temp. 103.4° last night, abdomen much distended, less dullness over the mass in right iliac fossa, but there is more tenderness; stools are looser, about one a day.

April 6. Hep. s. 3x 3 hours; acon. 1x nocte.

April 10. A consultation was held, and it was thought to be a case of appendicitis and operation recommended.

April 11. At 11.15 A. M. Mr. Shaw operated. As soon as the peritoneal cavity was opened one bead of pus was seen, but the opening made was filled by a mass of friable material, looking like lowly organized lymph. This was adherent to the peritoneum. No bowel was exposed to view and no pus cavity found, only a general matting together of the parts. Further operation was abandoned, and sutures and dressings applied.

April 13. Ars. iod. 3x given ter.

Much vomiting followed the operation and the patient gradually sank and died on April 15.

*Post-mortem.*—Only an extension of the abdominal wound was permitted. The abdominal cavity was seen to have all the organs matted together. Especially was this the case in the region of the swelling, where a large amount of new tubercular material had formed. The mesenteric glands and retroperitoneal glands had enlarged and suppurated. A specimen of the pus tested for the tuberculous bacillus readily yielded abundance of bacilli. The spleen was found to be full of tubercles, and the whole of the abdominal cavity infiltrated with tubercles. I am indebted to Dr. Galley Blackley for the notes of this case, the patient having been admitted from my out-patients under his care.

The foregoing cases I have selected as illustrating the

principal types of this disease. I think we are justified in concluding that in all cases *it is a very serious disease*. The tendency, if neglected or untreated, is to go from bad to worse. There is no doubt that it is one of the chief causes of death among the children of the poor, although the term they use, "consumptive bowels," probably includes other fatal forms of diarrhea.

In the next place the *course of the disease is variable, but generally chronic*. In the cases I have quoted, one only (Case V.) could be called acute; the rest were essentially chronic.

The prognosis varies. If treatment is commenced *early, most cases are curable*; but immense patience, care, and good wholesome food and general hygienic surroundings are essentials; without these relapses occur again and again.

Case II. is an instance of the success which follows long-continued, careful treatment, together with all the accessories of suitable diet and careful nursing which go to complete the treatment. The medicinal treatment is most important, and here is a disease for which homeopathy can do much, whereas allopathy can do little or nothing. The Case II. had been under allopathic treatment for one year, during which time the patient steadily got worse, and was most evidently saved by means of homeopathy.

In the narration of the cases I have mentioned the medicines used in each case, and I can only generalize now.

Iodide of arsenic 3 and 3x may be called the sheet anchor of this disease, and of tubercular lesions generally; then iodine 3, or combined with lime or sulph., as calc. iod. 3 or sulph. iod. 3x; apis 3x helps absorption of ascites; hepar s. 3 for the caseating glands; sulph. 3 or 30 as an intercurrent remedy. Calc. carb. 6 must not be forgotten, also calc. phosph. 3x. The special indications for the administration of these I need not remind you of.

It is not sufficient simply to give these medicines, or

rather I should say you will make far greater headway by a general survey of the peculiarities of your case, and treat accordingly. I am sure intestinal irrigation is of great use where the diarrhea is frequent and offensive. It is best given by means of a hydrostatic douche.

The question of diet is all important, and milk, boiled or peptonized, or humanized, stands first in importance. Raw meat sandwiches or one of the many meat juices may be given, but see that the diarrhea is not increased by so doing.

Cod-liver oil is highly beneficial, or some preparation which contains it. Inunctions of warm olive oil, or cocoa butter, are of great value in improving nutrition.

Massage must never be forgotten, and this may be preceded by the sea-bath, of the value of which I have the highest opinion.

Hitherto I have said little of the surgical treatment of cases of tuberculous peritonitis, except as it was employed in the treatment of Case V. It is a well-known fact that recovery has followed a simple exploratory abdominal incision, and the explanation I leave to the surgeons.

The remarks I have made and the conclusions I have drawn are based on my own observations, and I shall be interested to hear how far they coincide with those of my colleagues.

#### DISCUSSION.

DR. STORRAR (Southport), speaking as medical officer of a large children's sanatorium, said that scarcely a year passed without at least twenty such cases. They had some children in the sanatorium so affected now. In these the chief remedies relied upon were the fresh air of Southport, very careful feeding, chiefly on milk, and next the hydropathic compress, which had not been mentioned at all by Dr. Day. He attached very great importance indeed to this method of treatment. These things they had done every day—have the bowels thoroughly fomented with hot water; and all night, or all day if the patient were in bed, a wet compress, covered with oiled silk, was worn constantly. The remedies he had the most confidence in were calcarea carb. and calc

phos. If there should be any diarrhea, phosphoric acid nearly always answered the purpose of checking it perfectly well.

DR. MURRAY MOORE said there was one question he would like to ask with regard to the prevention of this disease—there was not one of them who had not seen a great deal of it in its three forms enumerated by Dr. Day—viz., whether, if they could insure the use of sterilized milk, or of milk from what was called a non-tuberculous dairy (of which they had one in Liverpool, which seemed to be patronized by the doctors and their families), this disease could not be in a large measure prevented. Also, he would ask Dr. Day whether he had seen any cases with that peculiar fetid diarrhea enumerated under the symptoms of psorinum, whether he had ever used psorinum 30 in that peculiar form of diarrhea usually associated with tuberculosis of the peritoneum. It seemed to him that they were pretty well confined to three or four medicines, all of which had an extremely definite and searching effect on these disorders—the three calcareas, carb., phos., and iod., the iodide of arsenicum, and lycopodium, in the 30th trituration. That in his hands had initiated the cure which calcarea had followed up. He would like to have Dr. Day's experiences of that particular medicine. He felt that they had listened to a most lucid and luminous paper, and he congratulated the London Homeopathic Hospital on having such an expert and able physician in the children's department.

DR. MIDGLEY CASH (Torquay) said he had recently a rather interesting case of a girl of fifteen, a butcher's daughter—such families were not generally affected by tubercle—in whom tuberculosis disease developed in the tarsus, afterward attacking the chest, and finally, when that became quiescent, the abdomen. He was glad to say that she passed through all that safely, and was now healthy and strong. That case illustrated the kind of treatment which Dr. Storrar seemed to think so useful. He used the abdominal compress, and had found it of great value, in conjunction mainly with iodine 3d decimal, and calcarea at times; these had proved of the greatest value. In the matter of feeding, he had found bovine very useful, given in milk. Extreme cases of marasmus, tubercular or otherwise, did very well on it. He had also found beneficial results from the rubbing in of cod liver oil on the abdomen in tubercular disease, and of terebine oil where the chest was affected. In cases where the patient could not take cod-liver oil, Angier's emulsion had proved a good substitute.

DR. NICHOLSON said they had heard a most useful paper, and his experience entirely endorsed its conclusions. Of preparations of calcarea he used for a long time the 3d decimal, but

in more recent years he had prescribed the 6th decimal. This he had found much more effective in children's diseases—a fact which surprised him very much. One question he would particularly like to ask Dr. Day with reference to the preparation of calcaria was, whether he had used the crude material, phos. of lime, such as the syrup of lime, in much older cases. In those cases he had found the syrup of lime act better than the potentized preparations. Calc. phos. he invariably used in low triturations.

DR. HUGHES (Brighton) remarked that he had, in common with all present, listened with the deepest interest to Dr. Day's paper, which was of a thoroughly practical and scientific character. It was just the kind of paper one looked for from physicians of hospitals—although one did not always get them. He hoped that the new scheme of hospital federation would bring them a crop of such papers. He had listened with special interest to case number two, because, as Dr. Day had told them, for a time he had the child in question under his care. He should like to emphasize the benefit she derived from iodine, before she came to him, under Dr. Day's excellent treatment. The child came to him (Dr. Hughes) in a very emaciated state, with no appetite, and he gave her nothing but iodine, keeping on steadily with it for three or four months while she was in Brighton, and during this time she steadily improved. She was a poor thing when she was sent to Dr. Day, but was a much poorer thing when she first came to him (Dr. Hughes). Loss of weight stopped, and after a time she began to gain a little. The size of the abdomen, by measurement, decidedly diminished, and the appetite returned. She had about one-third of an appetite when she left him, and she had none when she came. He was glad to find that iodine played a part in nearly all the remedies Dr. Day gave her afterward—iodide of arsenic, iodide of lime, iodide of sulphur. He thought that when they studied the symptoms of chronic iodism, they would see that hardly any drug resembled so exactly the condition of *tabes mesenterica* as that did, and, when combined with arsenic and lime, they would find it their most suitable remedy in the treatment of these diseases.

DR. ORD referred to his notes on three cases of special interest, bearing out what the reader of the paper had said. The first was that of a young lady of nineteen—a very dark girl, with long eyelashes, and of typically tuberculous appearance. She enjoyed good health, and there were no symptoms of tubercle, until she contracted a chill during her period—a year since last August. After this she had much pain at the several periods, and flooding. Then the periods ceased, and the bowels began to swell, this being especially noticeable after tea in the afternoon. She lost

flesh, but had no night sweats. The bowels having now become very considerably swollen, she came under allopathic treatment, when a tumor was diagnosed, and she was sent to the hospital for an operation. In hospital the abdomen was opened for the removal of the supposed tumor. The operation took place on March 20 of this year. Of course they found "tubercular peritonitis." The wound was sewn up again, and they sent her home as incurable, presumably to die, with this diagnosis of tubercular peritonitis. She came into his hands on April 17, or about a month after the operation. The wound had quite healed, but she was exceedingly emaciated, and had a hectic look, and her evening temperature was 100°. There was no diarrhea. The abdomen was swollen by a large, hard, ill-defined mass below the navel, and mostly toward the right side. As mentioned, there was no diarrhea, but constant abdominal pain, and flatulency after solid food. He ordered peptonized milk, petroleum emulsion with hypophosphites, which he had found very useful in cases of this kind, and iodide of arsenic. In a fortnight the patient had greatly improved in strength, but the abdominal symptoms remained the same. He then ordered *calcareo carbonica* and *pulsatilla*. The flatulence and abdominal swelling became slightly reduced during the month these remedies were given, and the patient gained one pound per week in weight. Altogether, there was a general improvement. On May 31 there had been no return of the period, and iodine 3x was ordered. On July 20 of the present year she came to see him, two months after the previous prescription, saying that she had been quite well since the last medicine, except for a slight bilious attack recently. The period had returned. There was no flatulence or abdominal swelling, and the hardness had almost disappeared, although there was still some amount of resistance. She had gained in flesh and could eat anything, considered herself quite well, and was about to return to business. The second case was that of a boy of ten, who came to the dispensary for an abdominal pain and swelling. In spite of treatment he steadily grew worse, and in a month's time his condition was as follows: In bed, with constant high temperature, averaging 102°, sweats, diarrhea, and some abdominal pain; the abdomen enormously distended, like a barrel—he had never seen it so swollen in a boy; tympanitic, and evidently some ascitic fluid was present. The patient was much emaciated, and lay with his legs drawn up, moaning; could not bear to be touched or spoken to. He remained in this condition for nearly two months, and it was a marvel that he should have survived. Other symptoms that developed were delirium and stupor, bladder irritability, and excessive tenderness of the abdomen. The remedies tried at first, and which proved useless,

were mercurius corrosivus, iodium, bryonia, and baptisia. When at the worst, arsenicum was commenced, and finding that this checked the diarrhea and fever, calc. carb. 6x was given intercurrently. From this time the boy slowly and steadily improved, and after taking these remedies for about two months he was running about and apparently quite well. The abdomen had gone down, though not quite to a natural size, being still rather swollen, but the lad was apparently all right, no swollen glands to be felt. He could eat anything except fruit; the bowels had been upset once or twice by indulgence in fruit, and he was not as strong as formerly. He was at his worst for quite three weeks—refused all nourishment, and took only water, with a very little milk. In these two apparently hopeless cases he thought the use of arsenicum and calcarea carbonica had produced marked results. He found terebine 3x relieved the bladder pain and the abdominal tenderness.

DR. MOIR (Manchester) joined with preceding speakers in thanking Dr. Day for his paper. His experience fully endorsed the value of the medicine that had been referred to as useful in abdominal tuberculosis—the iodides of arsenic, of lime, and sulphur. In considering the effects of this morbid state, they should remember that cases of it, even when apparently cured, often, if not always, seemed to show that some degree of weakness had been left behind, showing still a want of proper nutrition.

DR. BLACKLEY (Southport), referring to cases of tubercular marasmus in children where cod-liver oil could not be taken, spoke of the help he had derived from using some form of alcoholic stimulation.

DR. NANKIVELL said they had heard the iodide of arsenic and the other iodides testified to as being extremely useful. There was another preparation of arsenic that had not been mentioned, and that was the arsenite of lime, which he had found very valuable indeed in the 3d decimal trituration. He had found the iodide very useful when given either as an addition to cod-liver oil, in the oil, rendering it remarkably digestible, and easily taken, or else given in the pure material. In both these forms iodine might be given, in milk, in the 2d decimal, and in small doses in the 1st decimal, and the effects of the milk, oil, and iodine all seemed to be very much increased by this method of prescription.

DR. ROCHE laid stress on the importance of the point alluded to by Dr. Moir—care in watching for a relapse. They must not too hastily assume that patients were cured, when they might have gone into other hands. He had in mind several cases which had been attended by remarkable temporary improvement, but this



had been followed by very disappointing relapses later on. He would also mention one other medicine which had not been already touched upon, but which emphasized the value of iodine, and had also met the bowel symptoms where the diarrhea was troublesome, viz.: bin-iodide of mercury.

DR. STOPFORD spoke of the only too common prevalence of the characteristics of tubercular disease of the abdomen, and the difficulty of dealing with the disease. He thanked Dr. Day for his paper, and went on to urge the importance of the question of how the disease might be prevented. They ought to instill into the public mind, in the first place, that unhealthy marriages were a main factor in creating the disease. Secondly, they must urge the recognition of the well-ascertained fact that bad feeding and unhealthy surroundings contributed to the prevalence of the evil. If they could succeed in effectually impressing these well-proven facts upon the public, they would be doing a great deal toward sweeping away tubercular diseases in children. There was another point, in respect to which he felt sure that Dr. Day would agree with him, and that was that tuberculous milk was one of the supreme factors in aiding and abetting the disposition to the disease derived from hereditary sources. The unfortunate part of it was this, that in so many dairies throughout the country tuberculous stock was being used for the production of milk, and such milk, given to a child with chronic catarrh, would produce the tubercular condition. He thought it behooved them all to do their best to see that the milk supplied to their patients was derived from a healthy source.

DR. BURWOOD remarked that where children could not take cod-liver oil, they could eat sardines on toast. It would do them just as much good.

DR. ROBERSON DAY, replying on the discussion, said he had been exceedingly gratified to find that nearly all the speakers had corroborated the views he had put forth in his paper, and that there had been some very valuable additions suggested to the method of treatment he had set forth. It would be impossible to reply individually to so many speakers, but he would deal with one or two of the more prominent points. First, that alluded to by Dr. Stopford and one or two earlier speakers—the sterilization of milk. They could not too thoroughly insist upon the importance of that point. It was being taken up by commercial companies in large cities, and the managing authorities of large dairies were appointing special medical officers to see that the sources of the milk supply were pure, but in smaller towns and in the country it was impossible that the same assurance could be obtained. But medical men should make a point of urging the importance of the matter upon those connected with

the supplying of milk, with whom they came in contact, and should recommend their patients to get their milk, where possible, from those dairies where such investigation and testing was carried out. In some countries the supplying of non-tuberculous milk was made compulsory by law. That was not the case here, though the large dairies, such as the Aylesbury and the Express, were safeguarded by the herds being regularly subjected to these tests, and all tuberculous cows were put out. There was not the slightest doubt that children who were the offspring of a tainted stock must readily have their digestive systems upset, and this disease of *tabes mesenterica* was thereby invited. On the other hand, by careful supervision of diet they could undoubtedly prevent, or at any rate stave off, the serious consequences of heredity. He must thank the various speakers for the suggestions offered with reference to the administration of cod-liver oil, and iodine in the oil, and particularly the toothsome suggestion of Dr. Burwood as to sardines on toast, which none of them would be likely to forget.

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## FIBROID TUMORS COMPLICATING PREGNANCY.

By F. P. MCKINSTRY, M. D.

CASES of fibroid tumor complicating pregnancy, while not frequent, are so important as to warrant careful consideration of the subject by all who have to do with obstetrical work.

I will briefly cite the history of two cases occurring in my practice.

The first is of interest solely from its *negative* character, while the second was *positive* enough in its history to suit the most fastidious.

CASE I. Mrs. M. had for a number of years suffered with an intra-mural fibroid and had become much reduced by hemorrhage at each menstrual epoch. At the age of thirty-nine she became pregnant for the first time, and as her former medical adviser had removed from town I was engaged to attend her. I was not particularly elated, but cheerfully consented.

Strange to relate, she was delivered in a most commonplace manner, and made an uneventful recovery.

CASE II. Primipara, æt. forty-five. When called to her bedside, she had been having pains for several hours.

Upon examination I found the pelvis almost filled with a hard irregular mass.

By careful investigation I discovered a small opening on one side at the superior strait, through which I could distinguish the presenting part.

Realizing the gravity of the situation, counsel was called in, and we decided to telegraph Dr. Philander A. Harris, Obstetrician to the Paterson General Hospital.

After a careful examination, Dr. Harris was of the opinion that labor could only be terminated by Cæsarian section, and the patient was removed to the hospital and prepared for operation.

After etherization a final attempt was made to push the tumor aside and apply forceps, which with much difficulty was accomplished, though with the sacrifice of the child.

The patient made a good recovery, left the hospital in three weeks, and six months later the tumor had almost disappeared. Besides obstructing the outlet and mechanically interfering with delivery, there are other dangers incident to the presence of fibroids.

The occurrence of *post-partum* hemorrhage is the one most dreaded, yet Leavitt says the danger is not so great as is generally supposed, and my experience with Case I. would confirm his statement.

There is considerable danger of inversion of the uterus during or following the third stage of labor, when the tumor is pedunculated.

The presence of a tumor may cause the child to assume a malposition *in utero*, and lastly an interstitial fibroid may cause mural degeneration and predisposition to rupture of the uterus during labor.

Fortunately, many cases undergo absorption and disappear during the post-puerperal period, which is happily illustrated by my second case.

## THE USE OF IODINE IN POST-PARTUM AND UTERINE HEMORRHAGE.\*

BY RALPH W. HERBERT, M. D.

THERE is possibly no position in which a physician is placed wherein a life depends so entirely upon prompt action as in a case of *post-partum* hemorrhage.

If, after the delivery of a child, the mother is found to have a rapid pulse, great thirst, and a relaxed uterus, the greatest watchfulness is needed.

In all cases of *post-partum* hemorrhage, I immediately grasp the uterus externally with one hand, and introduce the other hand into the uterine cavity to be positive the placenta and blood clots are entirely removed. In the first two such cases I encountered in my early practice, the hemorrhage was due to portions of the placenta, about the size of a hen's egg, remaining in the uterus after the expulsion of the main portion. Upon removal of these detached portions, the hemorrhage immediately ceased.

I generally remove the secundines in the following manner: Immediately after the delivery of the child, I grasp with one hand the fundus through the relaxed walls of the abdomen, and by gentle kneading and pressure endeavor to stimulate the uterus to contract. I then seize the cord with the other hand, making gentle traction; being careful not to detach the cord. I continue the combined manipulations during every contraction, until the placenta is removed. I am very careful to twist the membranes into a cord as I remove the afterbirth.

In some cases external and internal manipulations, with the external application of cold water, will cause the uterus to contract, stopping the hemorrhage.

But in many cases these measures, even combined with the introduction of ice in the uterine cavity, or hot-water injections, will not control the hemorrhage.

\* Read before the State Homeopathic Society, Newark, May 4, 1897.

In such cases iodine has, in my hands, acted admirably.

I always carry in my obstetrical satchel a bottle of tincture of iodine, and some small antiseptic sponges. I saturate such a sponge with iodine and carry it up with my hand into the uterus, and thoroughly sponge the walls of this cavity. This treatment causes the uterus immediately to contract, and the hemorrhage ceases.

I have used iodine both in hemorrhage after labor, and in hemorrhage following abortion, with remarkable success and no bad after-effects.

I would report the following cases :

I was called to attend Mrs. K. in her second confinement; she had an easy labor, with good expulsive pains. The placenta was expelled about five minutes after the birth of the child, but was followed by a profuse hemorrhage.

On examination I found the uterus contracted at the fundus, but relaxed at the cervix, so that I could introduce my hand into the lower two-thirds of the uterus. Manipulation, application of cold water, etc., failing to arrest the hemorrhage, I applied iodine as before described, which caused such sudden contraction I was unable to remove the sponge at that time. Four hours later I removed the sponge without difficulty, the lochial flow was immediately established, and my patient made an excellent recovery.

CASE II. Mrs. C. was attended in labor by a midwife; the infant was born at 6 A. M. On account of inability to remove the placenta, a messenger was sent for me. I reached the house at 9.30 and found the placenta still *in utero*. I tried by manipulations to secure the expulsion of the placenta, but after two hours of steady treatment I only succeeded in detaching the cord. I then attempted the removal of the secundines with my placental forceps, but was instantly confronted with a severe hemorrhage. Realizing that prompt measures alone could save my patient's life, I immediately introduced my hand into the

uterus, and found the placenta adherent over the fundus and sides of the uterus. Using my finger nails as a curette, I worked for an hour removing little fragments of the placenta. This was followed by a relaxed condition of the uterus, and the hemorrhage continued. The use of iodine in same manner caused immediate contraction of the uterus, and the woman made an excellent, though retarded recovery.

The next case was Mrs. D., a primipara. She had been in hard labor for over five hours, and during the last three hours there had occurred no change in the position of the child. The patient showing symptoms of exhaustion, I put her under the influence of chloroform, and delivered her, with forceps, in a half hour. The placenta was normally delivered, but this removal was immediately followed by a very alarming hemorrhage.

The uterus was perfectly relaxed; cold applications, ice in the uterus, and manipulations had no effect in controlling the hemorrhage. The use of iodine by sponging completely arrested the hemorrhage, but did not contract the uterus; the uterus being in such a relaxed, flabby condition I could fold one part upon the other. It was only after a half hour of constant kneading and gentle pressure I succeeded in causing the uterus to contract. This patient made a good, though somewhat retarded recovery.

The last case was one of abortion. I was called to attend Mrs. B. in a case of abortion at about three months. She was delivered without trouble of both fetus and placenta. This was followed by a continual passive hemorrhage, with the expulsion about once a day of a blood clot covered with a membrane the exact shape of the interior of the uterus. The expulsion of these clots was attended with severe pain. This difficulty continuing for four weeks, a large number of such clots were expelled and the amount of blood lost was enormous.

Mrs. B. became very anæmic, she had anæmic murmur of

the heart, purpuric spots appeared on her legs, and I almost despaired of her recovery. I had tried all the remedies that seemed in any way indicated in the case. I had used douches of hot water, packing of the vagina, and other local treatment, but, in spite of all, the hemorrhage with these peculiar blood clots continued. As a last resort, I gave an injection, consisting of a dram of Churchill's iodine, in the uterus. I repeated this injection the next day with the complete cessation of the hemorrhage, and no returns of the clots. This injection caused no bad after-effect, but from that time the patient slowly came back to life and health. Of course her recovery was delayed, owing to the extremely anæmic condition.

Iodine locally applied seems to be an efficient excitant of uterine contractions; it acts promptly in causing contraction of all blood vessels within the range of its influence. It does not cause the tough coagula that are formed by the iron salts. Taking into consideration the early appearance of the lochia after its use, together with its marked antiseptic and antizymotic power, it seems to me iodine is worthy of careful attention in cases of *post-partum* and uterine hemorrhage.

In conclusion allow me to call your attention to the physiological action of iodine on the circulatory system, as given by the celebrated old-school authority, Dr. Philips, in his "Materia Medica and Therapeutics." Speaking of iodine and iodides he says: "After toxic doses, first palpitation and flushings, afterward faintness, pallor, and collapse occur. The blood itself does not seem to be affected unless it be rendered more fluid and disposed to exude, for a form of purpura, 'iodic purpura' has sometimes occurred under the use of iodide of potassium."

Dr. Fox records an illustration in an adult with syphilide, and convalescent from rheumatic fever. After the second dose of 5 grs., a copious eruption of purpura came out on the legs and arms. This gradually faded and again recurred

while the medicine was continued. The eruption came again under each of the alkaline iodides, especially the ammonium salt; iodism occurred at the same time, but the syphilide got well; there was no evidence of renal or other organic disease.

Dr. Stephen McKenzie attributed fatal purpura in an infant to one dose of  $2\frac{1}{2}$  grs. of the same medicine, but in his case the sequence is not so clear as in some others alluded to by him. Whatever the pathological processes may be, I am satisfied that tinct. of iodine is liable to cause hemorrhage from various organs, especially in phthisical subjects, and in those with uterine congestion.

Kress has observed hemorrhage from the lungs and uterus in poisoning by iodide of potassium and extravasations of blood have been found *post-mortem* in animals poisoned by iodoform.

We are not yet able to reconcile this hemorrhagic tendency with the clinical results obtained in the treatment of aneurism by iodide of potassium.

Dr. Hughes says, in his lecture on iodine and potassium iodide, "I am quite unable to see any difference in kind between the physiological effect of the two substances." Considering the above as the physiological action of iodine, is it improbable that the small quantity of iodine absorbed by local application acts homeopathically upon hemorrhage of the uterus?



## ABORTION.

BY PLINY RAND WATTS, M. D.

THE effects of abortion, both immediate and remote, are so profound as to demand and receive the most serious consideration of the gynecologist as well as the obstetrician and general practitioner. Abortion is undoubtedly on the increase. The number of premature births that occur annually is enormous. Every physician has his quota of cases, while a very large proportion of women who fall into the hands of gynecologists date their trouble from abortions.

It is not within the province of this paper to deal especially with the after effects; to tell what to do when the tubes contain pus or the ovaries become cystic, but to consider some of the causes that make abortion so frequent, its prevention, and the treatment at the time of its occurrence. In so doing, any birth that occurs before the age of viability will be considered an abortion. Its causes are manifold, yet in many individual cases no satisfactory cause can be determined. Among these there may be noted, violence, diseases, certain drugs, profound nervous shock. Within the pelvis, displacements, inflammations, tumors, and lacerations are the most frequent causes. Women having suffered from syphilis or gonorrhea are very prone to miscarry, and one miscarriage from any cause makes another a little more easy. But without doubt the greatest cause is the desire of pregnant women to rid themselves of the product of conception. I firmly believe that the fetal deaths produced by the pregnant women themselves, or at their solicitation, far outnumber those from all other causes combined. Many cases never come to the notice of the physician. The modern woman has become so proficient in this art, that with the catheter, or some other mechanical means at her command, she believes the doctor to be entirely superfluous. It is my experience, and

I believe that of others, that the majority of abortions I am called upon to treat belong to this latter class. They failed to get along well, and consequently medical aid was called in.

Romheld, in a study of 222 cases, gives the following figures regarding cause. In this list he finds syphilis accountable for 27 per cent.; flexions 25.5 per cent., metritis and endometritis 10 to 15 per cent. In my own practice syphilis is hardly a factor.

*Prevention.*—Prevention is an easy matter in many instances where the physician is in full touch and sympathy with his patient. Knowing the condition existing prior to pregnancy, an intelligent treatment is much less difficult. Healthy exercise is to be encouraged, violent positively prohibited. There is very little danger at the present time of drugs causing premature births, unless they are taken for that purpose, and then they are as likely to fail as succeed. Some authorities go so far as to declare, in the most positive terms, that there is no evidence that any drug taken into the stomach will produce abortion. I do believe, and here authorities are again at variance, that inhalations of turpentine are exceedingly dangerous to the fetus. I am aware that some of our best men do not agree upon this point, but a number of instances have occurred in my own experience that have forced this conclusion, consequently, I advise my pregnant patients to keep as far as possible from the offending substance, which is usually in the form of fresh paint.

The various forms of displacements are a prolific source of premature births and merit our earnest consideration. The backward and downward dislocations are the most prone to make trouble. An abortion from the forward position appears to me to be an almost impossibility, yet Romheld found it to be the cause in 3.5 per cent. of his cases. The correct prevention in these cases is to cure the dislocations, or at least to palliate them, and this opens up a broad field that at the present time can only be touched

upon. It was formerly supposed that pregnancy and the subsequent parturition was a cure all for uterine diseases, especially displacements. More recent observations, however, do not confirm this position. While it is true that many cases of malposition of the uterus are cured in this manner, the proportion of cures is much less than was formerly supposed. Very many of the lesser forms find permanent relief by having the uterus straightened out and kept so for several consecutive months. Such cases are cured by giving birth to a full time child. Proper and persistent post-puerperal treatment will to a considerable extent supplement the cures by parturition alone. The scope of this article is not, however, the cure of misplacements, and these interest us at the present time only so far as they are inimical to child bearing. Many diseased uteri can be made to perform their God-given function and yet continue diseased. A prolapsed organ may be propped up until the fetus becomes of sufficient size to hold it, and, after its duty has been faithfully performed, again lie down in absolute indifference to its owner's desire or comfort. A few cases may demand a radical operation, Alexander's ventral fixation, or some of the newer plastic operations.

An enlarged uterus, too heavy for its ligaments, must be reduced to approximate its normal size, and I believe boro-glyceride heads the long list of remedies that will do this, a list with which you are all familiar. Electricity is often a valuable aid in this condition and also in some forms of inflammation. If the enlargement comes from an old endometritis, curettement followed by gauze packing and later, if necessary, a pessary to assist in retaining its position will be satisfactory. If the uterus is infected, as it frequently is, by the streptococcus pyogenes or some other pathogenic germ, curettement is the more essential. If a cervical laceration is the cause, it must be repaired. There are but two practical ways in which a retroflexed or prolapsed uterus can be retained in position, aside from operative procedure, until the uterus attains the necessary size: by tampons and by pessaries. I do not believe in the

tampon for this purpose. It necessitates a frequent meddling with the uterus and so increases the danger of abortion, while the pessary once in position is allowed to remain as long as necessary. When possible, and it usually is, the womb should be replaced and a pessary fitted before impregnation takes place. During pregnancy, replacements will often cause the patient to abort and the pessary in no way interferes with conception. The pessary that I prefer for a backward, is a Hodge's, made of hard rubber, or some modification of it. By holding it over a lamp or common gas flame, the shape can be easily changed if necessary. In procidentia the treatment is the same as above, except that a different pessary is used. I use what I call, for want of a better name, "a doughnut pessary." It is shaped like a round doughnut with a hole in the center and is very satisfactory. While the pessary very often fails to cure the deviation, it does assist very materially in preventing the loss of the contents of the uterus.

In connection with the mechanical treatment all medical indications are of course met with appropriate remedies. In the absence of positive medical indications in a threatened abortion, I have many times bridged over a crisis by administering a full dose of morphine. This is one of the few instances when the inhibitory action of the alkaloid is of real benefit. It checks the pains and contractions and often brings the whole process to a standstill, where by intelligent care and treatment it can be held.

*Treatment.*—The chief danger in abortion is the absorption of some toxic substance and the resulting septicæmia. Hemorrhage occasionally claims a victim, but not so frequently as the former. If the case is uncomplicated, there is but little for the medical attendant to do. If the uterus has thoroughly evacuated its contents, simply let it alone. In the absence of special indications calling for the douche or antiseptics, their immediate post-puerperal use is wholly uncalled for and in inexperienced or careless hands may be productive of great harm. If, however, the fetus is still retained or some operative procedure become neces-

sary, the most rigid asepsis should be observed. When it becomes impossible to preserve the life of the fetus, or death has already taken place, *i. e.*, when an abortion has become an assured fact, the one thing necessary is to clear the uterus of all its contents. This becomes imperative and in its failure lies the chief danger. In no surgical procedure, for this has now become such, is carelessness productive of more harm. The smallest particle that may be retained is liable to become a nidus for decomposition and a culture medium for pathogenic germs. The question now arises, "What is the best method of emptying the uterus?" I have heard a number advise feeling over the endometrium with the index-finger and scraping away any adherent proportions with the finger nail as though it was the easiest thing in the world. I frankly confess that I cannot do this with any degree of satisfaction. In the early stages and often later the cervix is not dilated sufficiently to admit the finger. It is then necessary to fix the uterus by traction forceps and forcibly dilate. The cotton tampon pressed firmly against the cervix will often cause contractions, but this will never do as a routine practice. When it becomes necessary to interfere, my own practice is to dilate with the graduated hard rubber dilators or the steel dilator after the pattern of Goodell. The entire endometrium is then thoroughly curetted with a sharp and a preferably douche instrument and the uterus irrigated, usually with a boracic acid solution, or boiled water, or if purulent, a bichloride solution. Frequently infection has taken place before the physician is called, and here an immediate curettement is the more imperative. In these cases a sharp curette should always be used. If a uterus ever demands curettement a thorough one is necessary, and this cannot be done except with a sharp instrument. If any considerable progress has been made in pregnancy it has not been my practice to pack the uterus, the douche alone being necessary. The patient should be kept in bed two or three weeks or more, and the same care observed later as after a delivery at full time.

## A CASE OF INSANITY AND OOPHORO-EPILEPSY, CURED BY VAGINAL OOPHORO-HYSTERECTOMY.

BY A. A. WHIPPLE, M. D.

ON November 10, 1896, I was called to see Miss M., an unmarried woman, thirty-one years of age, and learned that she had been of unsound mind for the last ten years; that she had been gradually growing worse, and that for the past year or two she had become at times violently insane, and required constant watching.

I also learned that she had what her sister called "spells," which, I soon determined in my own mind, was what might, with propriety, be called hystero-, or oöphoro-epilepsy.

The patient had been under the care of physicians all of the time for the ten years, and had submitted to local treatments, all of which seemed to be of little if any benefit.

My first visit on the 10th, and the second on the 12th, was on account of what they called those "spells," but the paroxysm in each instance had passed when I arrived.

The next day I endeavored to make a digital examination of uterus and ovaries, but on account of her insane and ungovernable condition, and, as I soon found, the intense vaginismus, I was obliged to postpone the examination until such time as I could have things a little more my way.

On the 16th I took another physician with me to give chloroform, and while she was under the anæsthetic we made a thorough examination, but could not make out any very serious condition, except a retroflexion of the uterus, and chronic ovaritis, with vaginismus and a tight or spasmodic sphincter ani.

While the patient was under the anæsthetic I made a thorough dilatation of everything in sight, and did all other necessary orificial work in and about the several

apartments, or orifices, and informed the family that I would treat her medicinally for a few weeks, and if no improvement followed after a reasonable time, I advised a removal of the uterus and ovaries, believing that to be the only treatment that promised anything for her; at the same time assuring the family that I could not promise a cure even with that.

November and December passed, and the patient became more and more unmanageable. The family insisted on the operation being performed, feeling that even a fatal termination was far preferable to the unhappy condition which then existed.

With this understanding I sent her to the hospital on the first day of January, 1897. On the 5th I made a vaginal oöphoro-hysterectomy.

Found both ovaries slightly enlarged and sclerotic, with several small cysts in the left broad ligament. Uterus normal in size, but retroflexed.

Fearing violent symptoms as the anæsthetic passed away, I took the precaution to have the patient very thoroughly confined to the bed, and placed her in the care of a special nurse.

We soon found, however, that there was no need of such precaution, for the patient, as the anæsthetic passed away, was perfectly sane.

Her recovery was rapid, and really with no more serious symptoms than we often find in normal labor.

I dismissed her from the hospital on the 31st of January.

In writing an account of this case, I have waited purposely until the last day and the eleventh hour thereof, fearing there might be some recurrence of the symptoms; but so far she is in good health.

Her only complaint is that she has not become unwell.

## EARLY REPAIR OF LACERATIONS OF THE PERINEUM AND UTERINE CERVIX.\*

BY WM. DAVIS FOSTER, M. D.,

Professor of Surgery, Kansas City Homeopathic Medical College.

**I**T is asserted that every woman who gives birth to a child at term sustains more or less injury either to the perineum or cervix uteri, or to both; that every woman who is the victim of a criminal abortion surely has a torn cervix. A certain per cent. of these injuries is slight and may never be the cause of invalidism. A very large per cent. does cause a great variety of ailments and establish conditions which ultimately undermine the woman's health. The primary symptoms of a tear in the mouth of the uterus are not always very characteristic. In cases of rigid os and very rapid labors, followed by excessive hemorrhage, this accident may be suspected. In 1866 Dr. M. A. Pallen diagnosed this accident and made a successful primary operation for its cure. Similar proceedings have not been recorded in surgical literature. At the close of labor, when the vagina and uterus are bathed with the usual flow following delivery, it is difficult to discover by the most careful examination the exact extent of these tears, and yet more difficult to bring the margins of the torn surfaces into apposition and retain them there with sutures. So, generally, it happens that a secondary operation, if any, is resorted to for the remedy of this accident of labor. What, then, is the train of evils resulting from unattended lacerations of the cervix uteri? The list is long, the danger great and manifold, and, though often recited, will bear repetition at this time. We find a sense of weight in the pelvic region, backache, a constant tired feeling, loss of sexual desire, pain during coition or following it, an abundant, constant leucorrhœal discharge. Later the

\* Read before Missouri Institute of Homeopathy, 1897.



nervous system takes the alarm ; the woman loses sleep, becomes a complaining and hysterical creature, finally a confirmed invalid. In some cases these conditions develop rapidly, in others they appear gradually. In rare instances all these symptoms are present, and yet a critical examination fails to reveal a laceration which would account therefor. The truth is that Nature, in her efforts to repair this injury, sometimes covers up the signs of laceration. Its extent is only revealed when the attempt for its cure is made, by fully dilating the cervix under anæsthesia ; then the true condition is disclosed.

Lacerations of the perineum are very common. They are found after natural labor ; they are found after instrumental labor. The writer's experience teaches that many of the tears observed have been caused, not by the passage of the fetal head, but by the escape of the shoulders, during the descent of which the acromion process does the damage. It is now a growing practice to repair these hurts at once, yet it is surprising how frequently old lacerations are found. This injury, by removing the support of the pelvic floor, allows the uterus to prolapse. This dragging puts undue strain upon the vaginal walls, the broad ligaments, the bladder, etc., including congestions of the pelvic contents generally. Finally occurs a rectocele, a cystocele, and, in aggravated cases, complete procidentia uteri.

Is it necessary to go into a lengthy and labored argument to show that it is wise to repair these injuries early, before the melancholy conditions described become confirmed ? The importance of early repair is also further emphasized when it is remembered that a very large proportion of the cases of uterine cancer have their origin in the cicatricial tissue resulting from these injuries. It is now the consensus of opinion that a vast majority of cases of uterine cancer begin in old lacerations at the sites named.

HOW TO MAKE LABOR EASY AND IMPROVE  
THE RACE.\*

BY D. DUNCAN, A. M., M. D.,

Professor of Obstetrics in Dunham Medical College.

PSYCHOLOGICAL laws are as sure as physical laws; the action of the former is quicker and more lasting than the latter. If the pregnant woman wishes evil to another, it is certain to react on the embryo, and if the child lives, will plague her, and others, in the future; instead of the evil wish hurting the person who caused the bad thought, it becomes ingrained into the being of her child. Many an impulse to thieving is given by the mother to the child, by wishing for things without desiring to pay for them.

We must look to the parturient period as the means of elevating man, lifting him from the animal plane to the human. It is the *ante-natal*, and not the *post-natal*, that makes man a human being and not a brute.

Then how important it is that we should study the laws of our being, and, as we get the truth, how imperative that we should teach it!

It is not a law that woman any more than the lower animals should bring forth in pain, except as she violates the law of her being; or, as it was violated by her ancestors, parents and grandparents. Then, it is her physician's duty to know the laws of health, and direct her what she should do, in these, the most important periods of her life.

There are two sets of causes always operating on man, one from the interior, the other from the exterior. One from the father through the mother, and the other from the mother from diet, surroundings, etc., back on the fetus.

It is through the father that the soul (life) comes, and

\* Read before the Illinois Homeopathic Medical Association, May, 1897.

the mother furnishes the body, and very many mental peculiarities. Then the inherited tendencies from both parents will be given to the child, just in the degree that parents yield to or restrain these tendencies in themselves.

Thousands of cross, disobedient children, so-called ungrateful children, are born yearly, because one or both parents objected to their conception and mature birth. Two essential things are to be accomplished: First, to render labor easy, and without danger to mother or child; second, to improve the race. The first can be insured to a very great degree, by diet, baths, exercise, and the necessary homeopathic treatment. The second, by blending the right temperaments and physiques, and controlling the passions and thoughts during pregnancy. We know the most certain way to make labor easy is to keep the sutures open as much as possible, and the bones as soft as can be done without injury to the offspring. That system of medicines which alleviates the pains and danger of giving birth to man, confers the greatest blessing possible on the race.

In proportion as a woman subsists during pregnancy upon aliment which is free from earthy and bony matter will she avoid pain and danger in delivery, hence the more ripe fruit, acid fruit in particular, and the less of other kinds of foods, but particularly of bread or pastry of any kind, is consumed, the less will be the danger and sufferings of childbirth.

If the appetite in the earlier months, from the presence of morning sickness, is variable and capricious, let her not be persuaded to humor and feed its waywardness, from the belief that it is necessary to do so; for, if she does, she may depend upon it, from such indulgence, it will soon require a larger and more ample supply than is compatible with her own health or that of her little one.

If the general health before pregnancy was delicate and feeble, and, as a consequence of this state, becomes invigo-

rated and the powers of digestion increase, a larger supply of nourishment is demanded, and may be taken in such a care without fear ; for, instead of being injurious, it will be useful.

A woman, toward the conclusion of pregnancy, should be particularly careful not to be persuaded to eat in the proportion of two persons, for it may not only bring on vomiting, heartburn, constipation, etc., but will contribute, from the accumulation of impurities in the lower bowel, to the difficulties of labor.

Regularity in hours of eating is advantageous to the health ; and more care even than usual should be taken during pregnancy to observe this practice. Another important rule is, to eat nothing for at least three hours before going to bed. Next to diet, exercise in the open air, and sitz-baths, play an important part. The bath will relieve pruritus—the bath to be taken as often as the symptoms occur—also, congestion of the pelvic viscera, piles, etc. The bath should never be taken on a full stomach ; the best time is just before retiring.

I cannot too strongly recommend that the greatest attention should be given to the constitution and to the slightest symptoms of the pregnant woman, whose health has not been previously good, in order to administer the medicines proper to her case, because in this manner, besides the relief to the mother, we obtain an improvement in the constitution of the child about to be born, and for whom we prepare a robust health. It is thus that we shall succeed in regenerating and improving the human race.

If you believe that strong impressions upon the mother's mind may communicate themselves to the fetus, producing marks, deformity, etc., how much more should you believe that irritability, anger, grief, jealousy, hatred, discontent, or any perversion of disposition, may be impressed upon the child's moral and mental nature, rendering it weakly or nervous, passionate or morose, or, in some way, a reproduction of the mother's evil feelings !

It is the physician's duty to point out to the mothers what their diet should be, how to bathe and exercise, and above all, toward the end of their term, the great importance of controlling their tempers, and directing their thoughts. I believe, if physicians gave more attention to this subject, we ought to cause healthier children to be born, and prevent tubercular and scrofulous affections from developing in those families who intrust their lives to our care.

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## CANCER OF THE UTERUS AND VAGINAL HYSTERECTOMY.

BY A. E. NEUMEISTER, M. D.

CANCER of the uterus generally occurs between the ages of thirty and sixty, and more frequently between the ages of forty and sixty years. Women with too frequent childbirth and quick labor, generally causing laceration of the cervix uteri, especially those of hereditary history, are more prone to cancer of the uterus. The majority of fatal cases of uterine cancer are due to neglect on the part of the patient after having been informed by her physician and warned of consequences if an operation is not performed, but she puts it off from time to time until it is too late to operate, the disease having already accomplished its deadly work without the possibility of removal by operation.

Another class of patients suffer from pain and discharges from the vaginal tract for many years without consulting a physician about it; but, instead, listen to old women who have a cure for everything; while others fall into the hands of a lady canvasser of some patent cure like the so-called Orange Blossom treatment and many other sure cures sold in the drug shop. Yet another class, the older women, those who have passed the climacteric for many years and

in whom all at once, menstruation is re-established, flow at intervals, the character of the flow being a bright red color and which continues for one or two weeks at a time, while no especial inconvenience is experienced by the patient. No physician is consulted regarding it until the color of the flow has changed from a bright red to a dark color, with offensive odor, complicated with bearing-down and sharp, shooting pains at intervals, which are mistaken for neuralgia. The patient generally looks for relief from remedies alone. In the meantime, much valuable time is lost. When she is at last ready to be examined, informed of her condition, and a hysterectomy proposed, she will not consent until some medical and local treatment is tried first.

I had a number of such cases years ago, and I treated them locally with chloride of zinc, arsenic, and sanguinaria, which gave them temporary relief. The patient seemingly improved during the treatment, when, in fact, the disease spread and formed adhesions. I treated a case for two years, locally, until I got tired wasting time without any good results at all. I advised a vaginal hysterectomy, and by being firm in my decision she was ready for the operation, and I made a vaginal hysterectomy with a good recovery. The patient feels no inconvenience since the operation; the parts are perfectly healthy, and have been ever since the operation was performed, which was one year ago. I treated two more cases, in which I found the uterine cavity filled with pus. I dilated the cervical canal and made a thorough irrigation with permanganate of potash and packed the cavity every day for three weeks, but the discharge continued until I made a vaginal hysterectomy. The patient made a quick recovery, and is free from all pains and discharges. A third case suffered with dyspeptic pains, with inclination to bend forward. The uterus was bound down with adhesions and the omentum was adherent to the fundus uteri. The patient suffered with neuralgic

pains of the stomach, bowels, and hypogastric region. She was poorly nourished, although she had a good appetite and was ready to eat three meals every day, but each meal was followed by neuralgic pains of a reflex character. After treating the case for several years with remedies and local treatments, with no other results than to make the patient comfortable for the time during which she took treatment, I advised a vaginal hysterectomy, as a last resort, for relief, to which she readily consented. She was much reduced in flesh and too weak to walk, but she stood the operation well. I made the clamp operation and removed the clamps in seventy-two hours. The operation was almost a bloodless one and the patient made a rapid recovery, sitting up and walking around the room in two weeks' time after the operation. She has felt no inconvenience from her stomach, bowels, or hypogastric region since the operation. She eats heartily and sleeps well, and is gaining in weight every day.

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## THE PREVENTION OF FEMALE PELVIC DISEASE.

BY ELIAS C. PRICE, M. D.

HOW wide the field! From the prenatal medication in the mother, through infantile life, childhood, puberty, and womanhood; the management and treatment of the patient, the question of hygiene, exercise, dress reform, remedies, etc., etc.

A Scotch divine was once speaking of having upon one occasion preached for three hours, and was asked if he was not very tired. "Not at all," he said, "but it would have done *your heart good* to have seen *how tired* the people were."

It is a good thing for the physician to have the prospective mother under surveillance for a month or two

previous to her confinement. There was a time when I was silly enough before the confinement to give for five to six weeks remedies, regardless of any indications, that were reputed to give an easy labor, and was rewarded by having the most tedious labors I had ever had. I soon learned that it was a far better plan to give the indicated remedy, and if nothing was indicated, to give nothing. I have also tried the acid-fruit diet, but I think that has had its day. There is one thing about it that is good: if the patient is constipated, has her legs swell; feels stiff, clumsy, and heavy—if she will cut a lemon open twice a day, fill it with sugar and suck the juice out of it, or take the juice as a lemonade, she will soon feel a wonderful improvement.

The obstetrician's duty is to take charge of the labor; none of us want a case of *post-partum* hemorrhage; the *prevention* of which is *prophylactic treatment*. Immediately after the removal of the placenta, give the patient a teaspoonful of good cider vinegar in about two ounces of water. It will produce a cannon-ball-like contraction of the uterus, in from one to two minutes after it reaches the stomach. I formerly gave a tablespoonful at a dose, but that is too much, as it frequently produces emesis. A teaspoonful appears to act just as quickly as a tablespoonful. I have used it for ten or twelve years.

Ergot requires from twenty to thirty minutes to act, and if the patient has a robust constitution and rigid fibers it will not act at all. It only acts well on pale, weak, anæmic persons, made so by long sickness or profuse loss of blood; vinegar does not refuse its benign influence to any constitution or temperament.

After-pains are produced by the alternate contraction and relaxation of the uterus. Give a remedy that will produce and keep up permanent contraction of the uterus, and you will have no trouble with the after-pains. I formerly gave about three drops of fl. ext. of ergot every one or two



hours; now I put about half an ounce (one tablespoonful) of vinegar in about two ounces (four tablespoonfuls) of water, and give a teaspoonful every half to two hours, as may be necessary. Arn. 3x, cham. 12x, and acon. are also good remedies.

*Now what is to be done for the baby?*—As soon as it is oiled or greased, washed and dressed, unless the mother is exceedingly weak, I have the baby immediately applied to the breast: first, because the sooner the baby is applied to the breast, the easier it is to get it to nurse; second, because its nursing causes contraction of the uterus and is a safeguard against uterine hemorrhage; third, because the baby needs the colostrum, or first milk in the breast, to open its bowels.

Mothers should always give their daughters timely information about the new symptoms they may expect at a certain period of their lives; they should caution them not to be alarmed, and not to use any hazardous means for untimely suppression. I knew a young lady, many years ago, who had been kept in total ignorance. She was frightened almost to death. Instead of going to her mother she went to a schoolmate, whose reply was, "Why, that is nothing; do as I do. When I get tired of it, I put my feet in a bucket of cold water and stop it." She did so, and for two years she was a confirmed invalid.

Ladies should be very careful at that time not to get caught in a hard shower of rain, or to get their feet wet; if they are habitual sufferers at that time they should spend the first one or two days in bed, and should avoid all violent exercise during the whole period. Dysmenorrhea can be cured in three or four months by adopting the "no breakfast system," as recommended by Dr. Dewey.

Fisher women who become irregular in their menses during the winter months, when not following their usual avocation, have them restored to regularity when they go to work in the shoal sea-water in the summer, and are often

wet, up to their waists, nearly all day. Would warm sea-salt baths have the same effect?

*To prevent catching cold.*—If every person would sponge the face, neck, arms, and chest down to the waist in cold water every morning, and rub dry with a coarse towel, they would rarely take cold; if they begin in the early autumn they can use the water cold from the first, but if they commence in midwinter they should use it tepid for about a week, making it cooler every day. At the end of the week they can use the water that has stood in the room all night, or go to the bathroom and use it from the faucet.

I have frequently used teaspoonful doses of cod-liver oil in combination with Phillips' Wheat Phosphates to keep children from taking cold in winter. I prefer cod-liver oil that is pressed out of the livers and bottled before the fish has been out of the water twenty-four hours.

After confinement, I am very well satisfied if the patient's bowels are not moved until the fifth day, for the pelvic organs need rest. If the bowels are let alone they will generally be moved on the fifth day, sometimes sooner, but if they are not, I have the nurse give an enema of warm water.

During pregnancy if the bowels become constipated, and the limbs heavy and stiff, and painful on movement, I advise the juice of a lemon. Sometimes it is best to take two lemons a day; it has a remarkable effect in limbering up the extremities as well as relieving the constipation. Another good thing to relieve the constipation at any time is good country butter, churned in the old-fashioned barrel churn (creamery buttermilk has all the butter extracted and is of no use), or a plate of oatmeal, or cornmeal mush with about two ounces of molasses over it; this will generally open the bowels in about four hours.

I have often moved the bowels with coloc. and sulphur, given as follows: put a powder of coloc. 3x in six teaspoonfuls of water; a teaspoonful to be taken every half

hour, commencing at 7.30 A. M. After the medicine is exhausted, wait until 1 P. M., and then give the powder of sulphur 30x dry on the tongue. I have known it sometimes to move the bowels copiously.

*Dress reform.*—Ridicule it as you may, but the "Bloomer dress," or some modification of it, is the most suitable and sensible thing a woman can wear in cold and inclement weather.

Children should not, when taken out, be overdressed; more persons take cold by getting overheated than in any other way. On the other hand, they should be amply protected against changes of the weather.

*The curette.*—This not very formidable looking little instrument in my opinion is destined in the near future to create as much discussion in the medical profession as Sims' splitting the os uteri did some years ago. If you read the medical journals closely, I think you will conclude with me that, when many of the gynecologists get to work on the uterus, they think the job is not finished until they have curetted it, let the endometrium be ever so healthy. If the mucous membrane is once entirely scraped off, it is never replaced by true mucous membrane again, but by cicatricial tissue, which, being smooth, affords no soft velvety nest for the lodgment of the newly impregnated ovum, as the new mucous membrane does shortly after menstruation, but finding neither resting place nor nesting place, it slowly glides down and is precipitated into the vagina and finally extruded into the outer world.

The vagina, endometrium, and fallopian tubes are all thickly lined with minute villi, whose function it is, at the proper time, by their upward wave-like motion (being stimulated into action by the contact of the spermatozoa themselves) or by the orgasm, to carry the spermatozoa upward until one of them meets the descending ovum. Having met their consorts impregnation takes place right then and there; for some unknown reason they generally

appear to cease their migration ; they either attach themselves to, or settle down between the villi (barring enlargement), for a ten moons' tenure. Wherever the impregnated ovum rests, that becomes the place of attachment of the placenta. If the ovum rest anywhere in the cavity of the fundus of the uterus, you have a normal pregnancy ; if it rests in one of the fallopian tubes, you have a tubal pregnancy with its disastrous consequences.

Now, if you destroy the mucous membrane of the uterus by curetting, how are these villi to be reproduced ? What is to carry the spermatozoa upward to their destination, or what is to prevent the ovum from escaping downward and out of the uterus ?

You may ask me, how do you know that these statements are true ? In the course of a long and studious life, a man may receive many ideas that make an indelible impression upon his mind that, after the lapse of many years, he can no longer trace back their origin.

There are cases that can be explained upon no other hypothesis. Professor Richard Wilmot Hall of the University of Maryland related a case to the class, in 1846-47, that occurred in Paris. I was told of a case that occurred in Baltimore, and I have read of another case ; in all three cases there was the most conclusive evidence that there was no introitus, no orgasm, simply premature ejaculation ; the semen flowed over the labia, found entrance by some means, and impregnation took place. How many cases have been reported of women who were either profoundly under the influence of chloroform, or drunk from alcohol, that have been impregnated ?

I would like all gynecologists who may hear or read this carefully to turn over the leaves of their memory, and see if they can recollect a single case of conception in a patient whose uterus they have thoroughly curetted.

Curetting is quite frequently necessary ; it is only against the indiscriminate use, perhaps I should say abuse of it, that I am sounding the *tocsin of alarm*.

Cazeaux and Tarnier take a different view of conception from the one I have just mentioned. My idea is that it generally takes place in the cavity of the uterus. These authors say, in speaking of the necessity of the contact of the two elements, "But at what point does this contact occur? The experiments of Nuck and Haighton, who had rendered fecundation impossible by ligating the fallopian tubes, tended toward the conclusion that it occurred in the ovary; still this fact was not actually demonstrated, and it needed the definite proof of finding the spermatozoa on the ovary itself. At present there cannot be a further doubt on this point, for Bischoff has been fortunate enough to see them there. 'I had often seen,' says he, 'living and moving spermatozoa in the vagina, the womb and the fallopian tubes of bitches; but, on the 22d of June, 1838, I had the good fortune to perceive one on the ovary itself of a young bitch in heat for the first time; she copulated on the 21st, at seven o'clock in the evening, and again on the following day, at 2 o'clock P. M., and at the expiration of half an hour, that is, twenty-four after the first copulation, I killed her, and found some living spermatozoa, endowed with very active movements, not only in the vagina, the entire womb and tubes, but even between the fringes of the latter in the peritoneal pouch that surrounds the ovary, and on the surface of this organ itself, since that period, Wagner and Barry have made the same observation.

"Now, such results evidently prove that fecundation sometimes takes place in the ovary; but are we hence to conclude that it is possible in that organ alone? If spontaneous ovulation be now an incontestable fact, may it not be supposed, after having left the ovary, the ovum can encounter the spermatic fluid and become fecundated in the fallopian tubes, or even in the uterine cavity?

[M. Coste's observation seems, however, to prove that fecundation is almost always effected either upon the ovary or in the part of the tube nearest the fimbriated extremity;

inasmuch as he maintains the ovule spoils very quickly when it enters the tube without previous fecundation.]

"But the question arises, how does the fluid ejaculated by the male get as far as the ovary? We answer that, in the great majority of cases, it is evident that the sperm having first reached the uterus, upon the neck of which it was thrown by the *membrum virile*, travels through the tubes until it arrives there. This course is certainly due, 1st, to the movements proper of the womb and the tubes; for in the latter a rapid contraction is observed, following the direction from the vagina toward the ovaries, which, of course, is calculated to assist the progress of the sperm; and 2d, to the movements proper of the spermatozoa, which thus of themselves facilitate their own advancement.

"This first point being once established, the question naturally arises, What was the influence exercised by the sperm upon the ovule of the female during the contact? Now, numerous experiments clearly prove that the sperm owes its fecundating properties to the presence of the spermatric animalcules, and that, whenever it is deprived of these, it immediately becomes unsuited to its proper function. But, unfortunately, it is far more difficult to ascertain the part acted by the spermatozoa, though there have been three hypotheses started in regard to that subject deserving our consideration.

"Again, according to certain authors, the fecundating power does not belong to the spermatozoa, but to the seminal liquid interposed between them. In this hypothesis, the animalcules are the *transporters* of this fluid, and the object of their movements is to conduct it to the ovule.

"In the opinion of Bory-Saint-Vincent, Valentin, and Bischoff, the spermatozoa are solely destined to maintain the chemical composition of the sperm by their active motions. They suppose that the spermatric fluid is a substance endowed with a chemical sensibility of such a character that, like the blood, it can only preserve the

fecundating power while it remained in motion; whence these active elements are inclosed in it whose presence is indispensable—elements the movements of which are never more active than just at the moment when the semen leaves the place of its secretion, and which appear to exercise the most favorable influence for the maintenance of its composition.

“(The oldest view is, that during fecundation the spermatozoa penetrate directly into the ovum. Barry even asserted that there exists in the ova of rabbits an opening for this purpose, and he once had the good fortune to see a spermatozoon enter by means of the fissure.)

“For a long time this view was thoroughly contested, but has now come into favor again. In 1854, Meissonier saw in the ova of the rabbit spermatozoa within the transparent zone and in immediate contact with the yolk. The observation was verified by Wagner, Heale, and several others; and M. Coste, while examining the ova of trout and salmon, discovered in the viteline membrane a well-defined microscopic opening provided with an internal valve. In other ova, M. Robin saw spermatozoa inside the viteline membrane without being able to discover the opening through which they had passed.

“This is a summary of the most recent opinions. Whichever one may be adopted, the mind remains unsatisfied; for it must be acknowledged there is still a mystery that all the most ingenious hypotheses have failed to solve, and which will probably escape all our researches.”

So much for Cazeaux and Tarnier.

As the dog and the rabbit are endowed with more agility than the biped man, may not their spermatozoa possess the same characteristic?

## APPLICATION OF THE FORCEPS.\*

TRANSLATION BY B. F. UNDERWOOD, M. D.

(Continued from p. 476, September, 1897.)

**S**ECOND, left, pivoted blade—guided by the right hand—held in the left hand.

Introduction of the guiding hand. Now, for the second blade, the left, pivoted, it is the right hand which acts as guide. Introduce, without the thumb, backward and to the left, between the coccyx and the ischium as deeply as possible, until the commissure of the thumb is against the ileo-pubic symphyses; when the neck of the uterus will have been surely passed. It is now possible to follow the sagittal suture to the bregmatic fontanel and even to the frontal suture.

Presentation, introduction, and placing of the blade. Upon the right guiding hand, properly introduced, knowing its position, engage and conduct in its axis the left blade—the handle being lowered obliquely to bring it to the outside of the right forearm.

Do not hesitate to push the blade high, without force, however. It is necessary that the beak should pass beyond the forehead into an opening where it can remain, and which will permit the concavity of the blade to adapt itself easily and perfectly to the cephalic curvature. Without this condition the blade would not be able to glide finally, on the level of the head, upon the parieto-malar line, to the bregma, on account of the narrowness of the space which separates the forehead from the wall of the pelvis.

Figure 66. Vertex at the inferior strait in occipital right anterior position. Introduction backward, to the left, of the second guiding hand (the right without the thumb) and of the second blade, the left. The vulva is

\* From the French of Professor Farabeuf and Dr. Varnier.



greatly distended; the wrist rests upon the neck of the first blade. The handle of the blade about to be introduced, directed a little to the right of the median plane, is

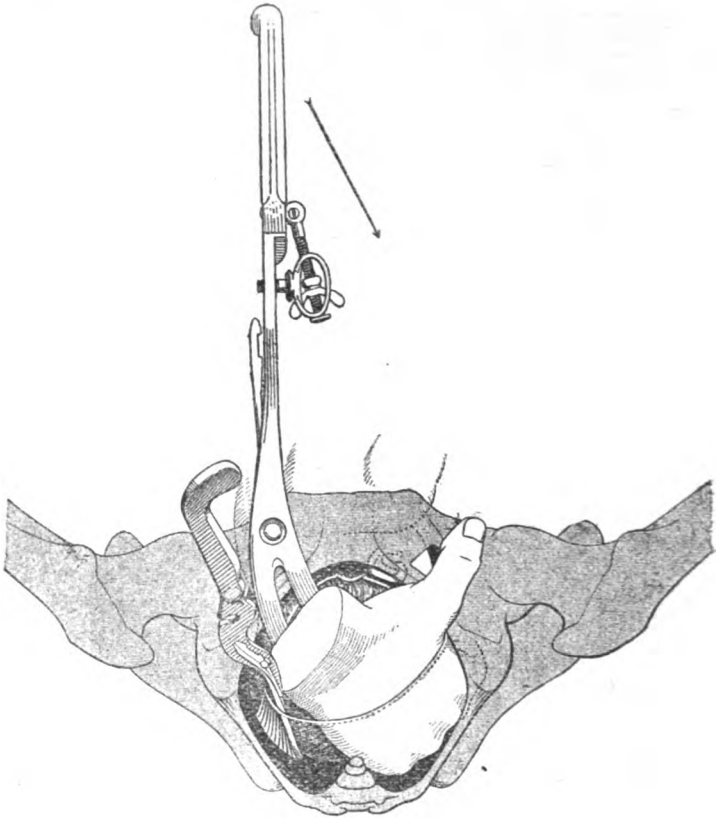


FIG. 66.

lowered obliquely, following the direction of the arrow which is parallel to the meridian of introduction.

Figure 67. To provoke the gliding movement necessary to bring the blade from the left posterior to the left anterior position, avoid displacing the head and the posterior blade in using the guiding hand. Act with the handle. This, brought from above and to the right, is

still raised above the horizontal level, to the left and near to the median plane; the hook turned obliquely upward and to the right like the taking surface of the blade. Simultaneously: lower the handle, for the beak must penetrate still further, bring it toward the right thigh, for the frontal eminence will throw the blade to the left, and finally turn and bring the hook, which is turned



FIG. 67.

obliquely, so that it looks directly to the right of the mother, for the purpose of causing the blade to glide forward. The maneuver is then half completed; the blade has passed the guiding hand and is upon the side. While retiring the guiding hand, continue to lower the handle so that the beak continues to rise; turn the hook to cause

the blade to glide forward upon the parieto-malar line. Stop only when the hook is turned obliquely downward and to the right. But the handle, considerably lowered, will come—that which carries the pivot—across the blade first applied: it is necessary to uncross them.

Figure 68. Vertex at the inferior strait in occipital right anterior position. Placing of the second, left blade, *G*, backward and to the left, then brought in front, *G'*, by a triple movement of translation, turning and continued

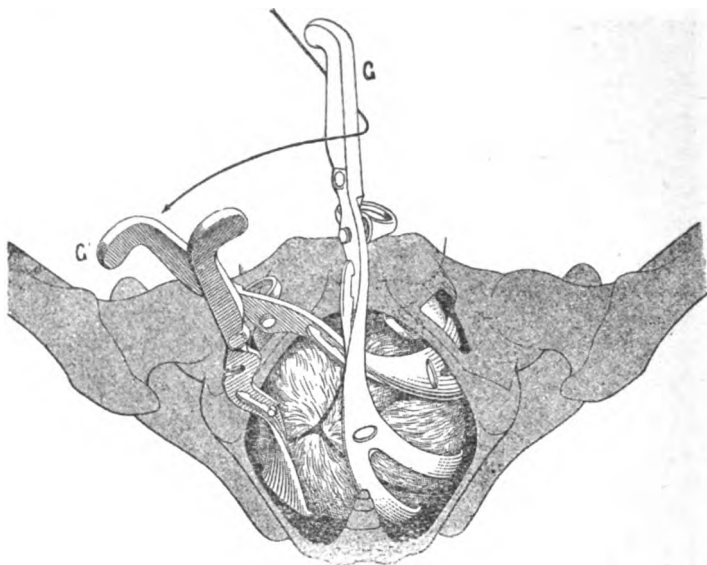


FIG. 68.

lowering, made by the handle. The hook descending obliquely, *G*, becomes first transverse and finally obliquely descendant, *G'*. The crossing is wrong; the pivot above the notch; it is necessary to uncross and recross them properly.

During all the time of this maneuver, the grand spiral movement of penetration which has directed the blade in the pelvic basin between the head and the uterine wall should be figured in the mind.

## ARTICULATION OF THE BLADES.

It is necessary, to make the articulation of the blades possible, to uncross the handles and then recross them so that the notch will come above the pivot. It should be remembered that the blade first placed, and consequently applied in the best conditions, should be disturbed as little as possible. It is therefore the left blade, having the pivot, which is to be brought across and about the right blade until it passes below. (See issue of January, 1897.)

If the forceps are properly placed the articulating surfaces will apply exactly. If the spiral movement has been too timidly made, if the blade has been arrested *en route*, encircling the frontal eminence and compressing the eye with the beak insufficiently entered, the articulating surfaces will not apply the one to the other. The blades may go even much farther without going far enough. Therefore for the articulation of the blades, sometimes it is the fault of placing the blades too far, sometimes not far enough. If the blade has not entered far enough, the handles should be turned slightly in an inverse sense to bring the articulating surfaces together. If, because of having entered too far, it is necessary to use force to bring the surfaces together the blade last introduced should be first withdrawn, then the other, by a reverse movement to their introduction. Carefully make the diagnosis again to be assured of the position and recommence the application.

## VERIFICATION.

The articulation being made. Notice again the oblique direction of the handles to the right, with regard to the median plane of the body. This will indicate that rotation has not been accomplished, of which you can assure yourself by touching the head with the finger above the forceps; you will feel the posterior fontanel in front and to the right; the sagittal suture designates always the right oblique diameter. The direction of the handles being what they should be for that position, you are sure that the application is correct.

## Book Reviews.

All manuscripts for publication, and all books for review, in this journal should be sent to the Publication Office, 133 William Street, New York.

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**LECTURES ON MENTAL AND NERVOUS DISEASES.** By CHARLES SINCLAIRE ELLIOTT, M. D., Professor of Nervous and Mental Diseases and Electro-Therapeutics in the College of Homeopathic Medicine and Surgery of the Kansas City University, etc., etc. New York : A. L. Chatterton & Co., 1897. Cloth, pp. 900, price \$5 ; leather, \$6 ; half morocco, \$7.

The basis of this valuable work, which thoroughly covers the field of mental and nervous diseases, giving the anatomy, physiology, pathology, and homeopathic and electro-therapeutics is the lectures delivered by the author at the Kansas City Homeopathic College for the past nine years. The work is a complete exposition of the subject and includes the main facts relating to mental and nervous disease, gathered and condensed from the works of all schools, from journals and from every available source, including the author's extended personal experience. It is particularly strong in therapeutics ; not only the homeopathic treatment being given in full, but also all adjuvant treatments which may assist in the relief or cure of the different disorders. The book is particularly intended for the general practitioner—to enable him to treat intelligently and successfully the more common disorders of the mind and nervous system—and the affections most likely to be met with in general practice receive the largest share of attention.

The instructions given for the therapeutic application of electricity are especially clear and complete, and will enable the novice in the use of this agent to apply it understandingly and scientifically to secure the best result. It is superior in this respect to many works devoted to electricity. The book is finely printed on good paper, and profusely illustrated, many of the illustrations being in colors ; and should have a large sale, as the best book upon the subject extant.

**MANUAL OF URINARY ANALYSIS**, containing a Systematic Course in Didactic and Laboratory Instruction for Students, together with Reference Tables and Clinical Data for Practitioners. By CLIFFORD MITCHELL, A. M., M. D. Illustrated. Price \$1.75. Chicago : Era Publishing Company, 1897.

This is an eminently practical work, and the best handbook on urinary analysis that we know of. It is concise, yet complete, accurate, and reliable, and thoroughly up to date. By the judicious use of different styles of type the author has been able to crowd into this modest book of 325 pages a vast amount of information such as the practitioner wants and which he can obtain nowhere else without a considerable expenditure of time and trouble. The arrangement is good, and the notes interspersing the text extremely valuable. In addition to all this the book is original, the author having drawn upon his accumulation of material derived from his examination of over three thousand specimens of twenty-four hour urine. The book is well printed and as fully illustrated as possible for a work of this kind.

**GROSS'S COMPARATIVE MATERIA MEDICA**. Edited by CONSTANTINE HERING. Second edition. Philadelphia : Boericke & Tafel, 1897. Half-morocco, \$6.00 net.

Outside in the yard are standing two pine trees, so much alike that to the careless observer they would appear to be each the duplicate of the other, but as they stand side by side the differences between them are accentuated and it can be seen that they are of different species. Apart they appear alike, but when brought together the difference is manifest. In a similar way the comparison of the closely resembling remedies of the homeopathic materia medica serves to point out the difference, so that once recognized it is always afterward clearly apparent. This is the sphere of Gross's "Comparative Materia Medica," to individualize the remedies of the homeopathist. It isn't a royal road to the mastery of the materia medica, for there are no royal roads to make the way easy, but rather a path through the woods along which the student must wearily plod until he becomes an expert woodsman. To drop metaphors, it may be said that the "Comparative Materia Medica" is an invaluable aid in acquiring a working knowledge of the homeopathic materia medica, which to the beginner appears as a bewildering mass of unrelated and

irrelevant symptoms, which are so duplicated and repeated that it becomes a confusion worse confounded, and it is only at the expense of much time and more effort that order begins to appear amid chaos. Undoubtedly all knowledge is acquired by comparison, by noting the likenesses and the differences, and this is what is done with the remedies brought together in the present volume. The book is a quarto with double column pages, the right hand column being given to the symptoms of one remedy, the left hand column to those of another, so that the similarity and the difference of the remedies can be seen at a glance. As a specimen of the work here is a portion of comparison of aconite and apis, as it appears on the first page :

ACONITE.	APIS.
The part affected is hot. Thirst.	The part affected is chilled. Thirst seems to be wanting, only during sweat.
Fear of loss of reason. Fear and sadness predominate.	Fear of apoplexy. Eccentric cheerfulness or hopefulness.
With horses : Inflammation of the brain : putting the head firmly against the wall.	With horses : Inflammation of the brain : runs the head furiously against the wall.

We find aconite thus compared with apis, arnica, belladonna, bryonia, cantharides, chamomilla, china, coffea, ignatia, nux vomica, opium, phosphorus, pulsatilla, rhus, veratrum. In this way there are given five hundred comparisons of one hundred of the most important of the remedies, so that the individuality of the different remedies is clearly set forth. The first edition of this work was issued thirty years ago, and was a favorite for study by the students of materia medica of that day, but as the edition was sold off it became among the rare books and almost unknown to the younger physicians. It is interesting to note that the most striking points of difference between the various remedies, the symptoms which serve most readily to distinguish them, are the ones which the improvers of the materia medica would remove by elimination. It is the odd, trifling, peculiar symptoms of a remedy which are the most distinctive. The comparative portion of the work is preceded by an introduction by Dr. Gross, which will well repay reading as throwing light upon the

intricacies of the *materia medica*, and an introduction by Dr. Hering showing how the book should be used. It has become somewhat trite to say of a book that every physician should have it, but we can truthfully say that every student of the *materia medica* will be greatly aided by a study of this work.

**DISEASES OF FEMALES AND CHILDREN, AND THEIR HOMEOPATHIC TREATMENT.** Containing also a full description of the dose of each medicine. By WALTER WILLIAMSON, M. D., Professor of *Materia Medica* and Therapeutics in the Homeopathic Medical College of Pennsylvania. Fourth Edition. Price, cloth, \$1.00. Philadelphia: Boericke & Tafel. 1897.

The everlasting truth of the homeopathic law of cure is well shown in the issuing of the fourth edition of this little book, which has long been out of print. While fashions and fads in medical treatment have come and gone since the first edition was issued, the therapeutic indications herein given are just as true and just as reliable as when first penned. There is a vitality and freshness in these books of the earlier generation of homeopaths that keeps them from ever growing old, and renders them more valuable than many of the newer ones.

**A TEXT-BOOK OF DISEASES OF WOMEN.** By CHARLES B. PENROSE, M. D., Ph. D., Professor of Gynecology in the University of Pennsylvania, Surgeon to the Gynecean Hospital, Philadelphia. Illustrated. Philadelphia: W. B. Saunders, 1897. pp. 529; octavo. Price \$3.50 net.

Compared with the former work, which represents the science and art of gynecology as understood and practiced in England, we have in this book the American view presented. The book has been written for the medical student and is especially adapted to this purpose. The author says: "I have written this book for the medical student. I have attempted to present the best teaching of modern gynecology, untrammelled by antiquated theories of methods of treatment. I have, in most instances, recommended but one plan of treatment for each disease, hoping in this way to avoid confusing the student or the physician who consults the book for practical guidance. I have, as a rule, omitted all facts of anatomy, physiology, and pathology which may be found in the general text-books upon these subjects. Such facts have been mentioned in detail only when it seemed



important for the elucidation of the subject, or when there were certain points in the pathology that were peculiar to the diseases under consideration." The book is profusely illustrated, well printed, and a most excellent book for the purpose for which it was written.

**DISEASES OF WOMEN.** By J. BLAND SUTTON, F. R. C. S., and ARTHUR E. GILES, M. D., B. A., F. R. C. S. 436 pp., handsomely illustrated. Price \$2.50 net. W. B. Saunders, Philadelphia, 1897.

The "Diseases of Women," by Drs. Sutton and Giles, is a practical work intended mainly for students and practitioners who desire a short and concise work upon a subject which has been voluminously written about. It is plainly and simply written, giving the facts and describing the methods belonging to the science and art of gynecology. The first chapters of the book are devoted to the anatomy and malformation of the female organs, the body of the book dealing with the various diseases of the vulva, vagina, uterus, etc., giving in full the cause, diagnosis, and treatment of each affection. Special attention is given in last dozen chapters to the technique of all the important gynecological operations. The book is finely illustrated and the various pathological changes and the technique of operative procedure are accurately represented.

**THE ESSENTIALS OF OBSTETRICS.** By CHARLES JEWETT, M. D., Professor of Obstetrics in the Long Island College Hospital, Brooklyn, N. Y. In one handsome 12mo volume of 356 pages, with 78 illustrations and 3 colored plates. Cloth, \$2.25. Lea Brothers & Co., publishers, New York and Philadelphia, 1897.

This, like the preceding books, is intended for the student, the author recognizing that the pupil in any department of learning succeeds best by first securing a systematic knowledge of its rudiments, for it is seldom that the average medical student has the necessary mental training to analyze his subject for himself. With this idea in view Dr. Jewett has consulted conciseness and clearness, and observed a systematic and logical arrangement, giving the most attention to practical topics. Having grasped the information contained in this book the student will be well grounded in the rudiments, and have the foundation well laid for

acquiring the complete and systematic knowledge of the subject. The book is freely illustrated both in color and in black, many being photographic representations, well elucidating the text. In the typographical arrangement a system has been followed which should materially aid the student in assimilating the material presented.

**THE PIONEERS OF HOMEOPATHY.** Compiled by THOMAS LINDSLEY BRADFORD, M. D., author of *Homeopathic Bibliography of the United States, etc., etc.* Philadelphia : Boericke & Tafel, 1897. Price, cloth, \$3.00.

The pioneers of homeopathy, who, when homeopathy was ridiculed by the majority of physicians as mere moonshine, had the courage of their convictions, and by their faith and their works laid down the foundation, broad and firm, upon which has been erected the homeopathic structure of to-day, have never received the modicum of fame their labors deserved ; many of them have been entirely forgotten. This book is therefore a timely one in rescuing from oblivion the names of those who assisted in the firm establishment of the homeopathic art of cure. The first part of the book is devoted to an account of the pioneer powers of the homeopathic materia medica. The second part to the biographies of all the persons who were practicing homeopathy previous to the year 1835. As can be readily seen the task has not been easy, and a less persevering author than Dr. Bradford would scarcely have succeeded in gathering the material for the work. Much of enthusiasm, much of encouragement, and more of hope for the future can be gained from the reading of the brief biographies of these physicians, who, in spite of obloquy, of contempt, and of open hostility, opened the way and made pleasant the path for those who came after them.

**THE SCIENTIFIC BASIS OF MEDICINE.** By I. W. HEYSINGER, M. A., M. D., author of "The Source and Mode of Solar Energy Throughout the Universe," "The Battle Against Prosperity," etc. Price 50 cents. Philadelphia : Boericke & Tafel, 1897.

The purpose of this book is to point out the historical and scientific principles of modern medicine, which were first demonstrated, systematized, and presented in a complete but ever expanding form by Hahnemann, and which are, in brief, to match the proved activities of drugs against the corresponding activities

of disease, and so extinguish or annul morbid processes and restore the normal rhythm of health again.

This principle of extinguishment by interference when first announced by Hahnemann was denounced as unscientific, but is now universally conceded to be correct. The book is interestingly and strongly written and well repays reading.

**THE MENOPAUSE.** A Consideration of the Phenomena which Occur to Women at the Close of the Child-bearing Period, with Incidental Allusions to Their Relationship to Menstruation. Also a Particular Consideration of the Premature (especially the Artificial) Menopause. By ANDREW F. CURRIER, A. B., M. D. New York : D. Appleton & Co.

The menopause is a subject which has received but scant attention from writers upon gynecological subjects, and it has been many years since an original work upon this subject in the English language has appeared, Tilt's work, which has long been out of print, being the last if not the only one. In the opinion of Dr. Currier the menopause is not a dangerous time or experience for the majority of women, an opinion in which we think most physicians will coincide. That many women suffer more or less at the time of the climacteric is undeniable, but the most common conditions are of a nervous character and referable to vasomotor influences, and if a woman be neurotic the influence exerted by the menopause will be more marked. The author objects to the old notion that the cessation of menstruation will bring a cure for hemorrhage, tumors, and ill-health generally; and insists that there is no intimate relationship between malignant disease, especially cancer of the breast and of the womb, and the menopause; and yet there can be no doubt that many women are permanently relieved of nervous disorders, headaches, nervous irritability, etc., with the cessation of menstruation. Regarding the treatment of the affections attending the menopause, the author advocates an early resort to surgical measures when indicated, and not to rely entirely upon internal medicine. Great stress is also laid upon the subject of the artificial menopause, which the author favors. "I would therefore submit," he says, "that the day has passed for any rational man or woman to urge the sterilizing or unsexing effect of the removal of the ovaries as a valid excuse in cases in which the operation is indicated." We do

not believe that any rational man or woman objects to the removal of the ovaries when necessity demands it, but there is unimpeachable testimony to the effect that in numerous cases the ovaries have been removed when the necessity did not exist, and women have been unsexed for trifling and inadequate reasons. The book is well arranged as to classification and consideration of the various portions of the subject. The headings are further arranged to form a running commentary, or, perhaps, synopsis is the better word, and this increases the practical nature of the volume and its value to the student.

The table of contents amounts practically to an author's summary of matter elaborated in the text, and there is in addition a full index of subjects, and a list of authors quoted.

**PRINCIPLES OF MEDICINE.** Designed for use as a Text-book in Medical Colleges. By CHARLES S. MACK, M. D., Professor of Materia Medica and Therapeutics in the Hahnemann Medical College, Chicago. Chicago: W. T. Kerner Co., 1897. Cloth, \$1.00 net.

This little work is a discussion of the principles of medical practice: homeopathy, rational medicine, and empiricism; the object of the book being to show just what is the cure sought in any given practice of homeopathy—that the cure cannot be intelligently attempted excepting under guidance of *similia similibus curantur* as law, and that one may consistently accept homeopathy and at the same time whatever else is good in medicine, which would appear not to require demonstrating. The various chapters are largely composed of papers read before medical societies or of lectures delivered to the student of medical colleges, and appear to contain much of interest and value for students of medicine.

**ANSWERS TO QUESTIONS CONCERNING HOMEOPATHY.** By J. T. BIDDLE, A. M., M. D. Philadelphia: Boericke & Tafel, 1897. \$4.00 per 1000.

This pamphlet, which is intended to answer the many question about homeopathy asked by those who are not familiar with this system, is an excellent thing to put in the hands of those looking for light. The many advantages of the homeopathic treatment are succinctly set forth in an attractive manner.

**THE ELECTRO-THERAPEUTIC GUIDE.** By WM. F. HOWE, M. D., Ph. D. Indianapolis: Wm. F. Howe, M. D., 1897.

This little work, by the editor of *The Electro-Therapeutist*, a monthly journal of electro-therapeutics for the general practitioner, is intended as a guide to the correct use of electricity by the general practitioner. It is succinct, practical, clear, and gives in brief space the essentials of electro-therapeutics.

## Materia Medica.

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***Conium in Ovarian Disease.***—Induration and enlargement of ovary, with nausea, vomiting, eructations of gas; lancinating pains; labor-like contractions: pains in iliac region; white, acrid, slimy leucorrhœa, are strong indications for conium.

***Antimonium Tartaricum in Whooping Cough.***—The child is irritable, cross, and cries when approached; coughs whenever it gets angry or after eating, the cough culminates in the vomiting of food and mucus, much rattling of mucus in chest without much expectoration. Coughing and gaping consecutively, tongue coated, white, thick, pasty coating.

***Arsenicum in the Albuminuria of Pregnancy.***—Dr. G. M. Christine.—This remedy is indicated when the urine is albuminous, due to hyperæmia of the kidneys. Casts are abundant, and the quantity of the urine is increased. Arsenicum is useful in catarrhal conditions of the renal mucosa, and in catarrh of the bladder and urethra, with restlessness, prostration, anæmia, and dropsical conditions.

***Kali Phosphoricum in Labor.***—Dr. Holbrook.—Kali phos. is an excitant of labor pains; when labor pains are irregular and weak no remedy acts more efficaciously than kali phosphoricum. It is also claimed that, where this remedy has been given steadily several weeks before labor confinement becomes in many cases a much less painful procedure. It is recommended either in the 3d or 6th, a small dose daily.

***Thlaspi in Dysmenorrhea.***—The menses anticipate; very little on the first day, on the second day a hemorrhage, with severe colic; vomiting and expulsion of clots; flow continued eight, ten, even fifteen days and left patient exhausted, from which she had not time to recover before next period. Every alternate period very profuse; one of the few remedies in the materia medica with this peculiar symptom.

***Sulphur in Diarrhea of Infants.***—Dr. H. O. Hathaway.—A child seven months old. Diarrhea for four days; ten or twelve movements a day; child cachectic. Pathogenetic symptoms:

Stool semi-fluid, frequent, copious, yellowish-green, very offensive, fetid; patient's skin smells bad; dry cough; rattling of mucus in the trachea. Sulphur 3 given for three days; marked improvement after the first dose. Five days later all the symptoms were cured and the child was much improved in general appearance.

**Magnesia Phos. in Menstrual Colic.**—Dr. C. C. Huff.—In menstrual colic, where the pains are characteristic, knife-like, cutting, stabbing, piercing, darting like streaks of lightning, and changing place rapidly, if you can positively determine that the pains are ovarian, then mag. phos. is the remedy; but if, on the contrary, the broad ligament is involved, you had better select another.

**Xanthoxylum in Dysmenorrhea.**—Dr. Barrow.—Miss R., aged twenty-seven, had suffered for years from dysmenorrhea. Her sufferings at the menstrual period were so great that life became almost unbearable. She had tried all kinds of treatment without obtaining the slightest benefits. She had been an in-patient at the Royal Infirmary, where she was told she had a "conical cervix," and under chloroform an operation was performed. This did not result in any relief to her sufferings, the catamenia being accompanied as usual with violent pains. Two years after the operation Miss R., worn to a skeleton with suffering and despairing of getting relief, came under the notice of the writer. He prescribed xanthoxylum, *ix ter die*, a fortnight before the menstrual period. In due time the menses appeared, and, to the great joy of the patient, there was very little pain. The remedy was continued for some time, and when left off the patient was completely cured.

**Equisetum in Post-Partum Retention of Urine.**—Dr. Ord of Bournemouth refers to the case of a woman who had always suffered from retention of urine after parturition, generally requiring the catheter for a week or more. After the birth of her last child the retention was accompanied by much distress and nervousness, with tenesmus. For two days belladonna  $\Phi$  in drop doses relieved, and then failed. Having seen equisetum highly recommended in this condition, some specimens of equisetum were obtained, and at once placed in alcohol, and in an

hour's time a fresh plant tincture, about 1x strength, was thus obtained. This was given in 5-drop doses every hour, with immediate relief. Water was passed naturally after the second dose, and there was no recurrence of the trouble. He has since used the same tincture in a case of retention, during peritoneal crises following dysmenorrhea, in a very neurotic patient with equally satisfactory results.

***Ferrum in Leucorrhœa.***—Dr. T. F. Allen.—Leucorrhœa, acrid, vagina painful after severe hemorrhage; face pale, bloated; skin pale, pits on pressure, uterine hemorrhage, menses profuse.

***Ammonium Carbonicum in Scarlet Fever.***—Stoppage of nose at night, child must breathe through mouth; long-lasting coryza. The child's nose is stopped; it starts from sleep; nose bleeds when washing face or hands; tonsils swollen, bluish, covered with offensive mucus; tendency to gangrenous ulceration of tonsils, eruption bright red, miliary rash. Is indicated where rash recedes too early and paralysis of brain threatens. Malignant cases with stupor, starting from sleep, putrid sore throat, saliva adhesion, swelling of parotid and cervical glands, stertorous breathing, excessive vomiting, and involuntary stools. When diphtheritic complications ensue and the tendency is to gangrenous destruction, ammonium carbonicum is especially useful.

***Bromine in Ovarian Disease.***—Dr. C. L. Olds.—The menstrual flow is too early, and of a bright red color. Preceding the menses there will be pains in the abdomen, particularly in the ovary, boring in the left ovary, lancinating pains in the back; headache before the menses come on. During the menses there may be an escape of flatus from the vagina. This is a peculiar symptom, and it has been found in cases of dysmenorrhea—membranous dysmenorrhea. Dysmenorrhea with escape of wind from the vagina when the other symptoms of bromine agree. She cannot bear coition, feels no thrill, and every time she has coition feels this lancinating, boring pain in the ovary. The ovaries, like the other glands, enlarge and become indurated.

***Pulsatilla as a Uterine Remedy.***—Dr. A. C. Cowperthwaite.—*Pulsatilla* clinically stands at the head of our uterine remedies, but its pathogenetic effects upon the uterus are not so decidedly pronounced as they are in several other drugs. Not only do we

find the general catarrhal effects of *pulsatilla* manifest upon the endometrium, but also many other evidences of deranged function, arising in all probability through the influence of the drug upon the cerebro-spinal system. There is no evidence that *pulsatilla* produces any tissue changes, but its functional disturbances are quite numerous. The acrid, milky leucorrhœa, and the well-known irregularities of menstruation, are the most important. A heavy, pressive pain in the small of the back is the most constant symptom. The *pulsatilla* temperament and the gastric derangements so characteristic of the drug must not be overlooked. So, too, should we remember the usefulness of *pulsatilla* in disorders of pregnancy and after parturition. It is said, among other things, to correct malpositions of the fetus, by altering abnormal conditions of the uterus.

***Millefolium in Threatened Abortion.***—Dr. L. L. Danforth.—Painless drainings from uterus, nose, or lungs, after labor, after abortion, or when an abortion threatens, if the blood be bright red and there are no pains in joints.

***Aconite in Backache.***—Dr. Tremaine.—Clinique.—*Aconite* is especially helpful in plethoric women who have a bruised, sore, stiff back; pains as if beaten, after checked perspiration, after a sudden fright or vexation; leucorrhœa copious, tenacious, yellow.

***Crocus in Menorrhagia.***—This is one of the most frequently indicated and one of the best remedies in menorrhagia. The menstrual discharge is profuse, lasts too long, recurs too frequently; blood black, stringy, sticky, clotted. Sensation as of something alive in the abdomen.

***Naja-trip. in Ovarian Neuralgia.***—Dr. McMichael.—Violent cramping pains in region of left ovary, pain simultaneously in heart and left ovary, pains sharp and cutting before menses, growing worse until flow begins, then easier until next month.

Concomitants: All symptoms better walking in open air. Sad and despondent.

***Kreasote in Diseases of Women.***—Dr. C. A. Dewey.—The menstruation of *kreasote* is usually copious and is accompanied with humming and roaring in the head. The flow may be intermittent and accompanied by dragging downward in the back. It differs from *sepia* in that the flow is early and profuse, while that



of sepia is late and scanty. The menses are apt to be followed by dark-brown, offensive leucorrhœa.

The leucorrhœa of kreasote is very characteristic. The discharge is very acrid and excoriates the parts which it touches; it is yellow, the patient is weak, there is violent itching of the vagina and smarting and burning between the thighs; the parts become swollen, hot, hard, and sore. After the leucorrhœa has continued for some time it has an odor of green corn. This acidity of the leucorrhœa readily distinguishes kreasote from sepia and murex.

In displacements kreasote is very useful, especially in prolapsus uteri. There is dragging in the back and a dragging downward, which are relieved by motion, thus distinguishing it from sepia and nux vomica. Kreasote is a useful remedy in ulcerations about the female organs, with offensive excoriating discharge, with burning pain, heat, and soreness.

***Zincum Metallicum in Dysmenorrhœa.***—Dr. Dahlke.—Pain in the left ovary, disappearing during the menstrual flow. Amelioration when the secretion appears.

***Sepia in Backache.***—Dr. W. A. Dewey.—Sepia is very frequently indicated in the backaches of women which are due to uterine disease. It is a general weakness in the small of the back when walking, and is worse while sitting. Sudden pain in the back, as if struck by a hammer, relieved by pressing back against something hard. Æsculus is often a useful remedy in backache which, like sepia's, is worse when walking. It is a severe, dull aching in the lumbo-sacral region, affecting the sacrum and hips. Backache during pregnancy will often be indicative of æsculus.

***Arum Triphyllum in Measles.***—Dr. L. C. McElwee.—Sensation as of myriads of invisible insects biting at every portion of the body; children pick and pick and pick at a given point, or bore into the nose, which is sore and sensitive, or bite the finger nails until they bleed. If old enough to talk, will often complain of distressing smarting in the throat.

Nothing seems to be an anodyne to them, and the vital fluids seem speedily to decompose. The patient rapidly passes into what is known as a typhoid condition and, unless something is done, will pass into a worse than typhoid condition—the hands

of the undertaker. I have only seen three or four such cases, but arum has relieved them beautifully.

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## Gynecological Etchings.

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**Amenorrhœa Virginalis.**—Dr. Edelheit (Wien. med. Presse) claims to have discovered a new disease, to which he gives the name of amenorrhœa virginalis, which is in no way connected with cessation of menstruation from chlorosis, anæmia, etc., but is in itself a primary and serious affection. It occurs in young women, and the first symptom is the amenorrhœa, which may or may not be associated with vicarious menstruation. After a while cardiac symptoms supervene, especially palpitation, dyspnœa, and cyanosis; eventually the right heart fails, and œdema and death result. He quotes two fatal cases, the patients being twenty and twenty-three years old respectively. In a third œdema of the lungs supervened acutely, and was only relieved by venesection. after which menstruation returned and became regular, the patient recovering; in all cases some good resulted, temporarily at any rate, from blood-letting. In a fourth case the patient married without the menses having reappeared; she became pregnant in a month or two, and all the symptoms—palpitation, headache, angina, dyspnœa, etc.—vanished. This girl had epistaxis at monthly intervals. The only pathological changes found after death have been hyperæmia of the endometrium, and in one case cystic degeneration of the ovaries. He considers that the suppression of the menses leads to general plethora, cardiac hypertrophy, valvular incompetence, and finally enormous pulmonary congestion.

**Chlorosis.**—Dr. Biernacki.—Vien. med. Woch.—The diagnosis of chlorosis is often difficult, as none of the symptoms can be considered pathognomonic. Much stress has been laid on the color of the skin, and this has generally been supposed to be due to deficiency of hemoglobin; but this appears to be incorrect, for with the appearance of profound anæmia there is often only

the slightest chemical change in the blood, while with no apparent anæmia the change may be profound. The color of the skin does not necessarily depend on the amount of hemoglobin present ; there are other coloring matters in the blood of which little is known at present, and it is to these that the color of the skin is due in chlorosis. Many of the symptoms—for example, dyspnœa, headache, etc.—have been attributed to deficiency of oxygen consequent on the deficiency of hemoglobin, but deficiency of hemoglobin does not necessarily diminish the amount of oxygen present, for it has been shown that there may be even more oxygen than normal in such blood. But great stress is to be laid on the clear appearance of chlorotic blood, and it is to this clearness, due to some anomaly of the blood pigments, in which hemoglobin plays little or no part, that the color of the skin is due. The color of the skin, however, is not essential to the diagnosis of chlorosis, which may exist with healthy-colored cheeks ; in woman at the climacteric symptoms are sometimes seen exactly like those of chlorosis, with the exception of the color. The most constant change in the blood in chlorosis is hydræmia,—that is, deficiency of albuminous bodies—and although the prognosis of chlorosis cannot at present be determined by examination of the blood, the writer fancies that cases with profound hydræmia get well more quickly than those with only slight hydræmia.

***Relations between Ovulation and Menstruation.***—Dr. L. M. Bossi.—*Annali di Ostet. e Ginecol.*—The problem regarding the relation of menstruation to ovulation is even more complex than has been commonly thought. In one case the patient, a married woman of twenty-five, had suffered since she was seventeen from enterorrhagia occurring monthly, associated with hysteriform attacks (also monthly). Since marriage the bleeding from the anus and other troubles had become worse, and coitus was impossible. It was found that the vagina was absent, and that the uterus and ovaries were infantile in type. An unsuccessful attempt was made to establish a vaginal canal. In the second case the woman, aged thirty-seven, had at first menstruated regularly, but later had suffered from menorrhagia. Curettage was twice performed, but without effect. Then vaginal hysterectomy was performed, and during its performance no

trace of either ovaries or tubes was found. Two hours after the operation the patient nearly died of hemorrhage from the abdominal arrangement of vaginal vessels which was present. In a third case there were periodic (monthly) convulsions, which had lasted for three years (since the age of seventeen), there was absence of the vagina, the uterus was infantile, and the ovaries lay in the inguinal ring, one on each side. There was complete amenorrhœa. Both ovaries were removed, and the convulsions ceased. The ovaries were large, and each showed a recent corpus luteum. These cases, as well as the fourth, show that no rule can yet be laid down regarding the relations of ovulation and menstruation. The second case especially is interesting and puzzling, for, notwithstanding the absence of tubes and ovaries, hysterectomy was necessary for menorrhagia.

*Peri-uterine Hematocoele.*—Dr. Pestalozza (*Acti della Soc. Ital. di Ost. e Gin.*) considers this condition to be commonly due to tubal abortion, next to the intraperitoneal rupture of a tubal pregnancy; it may much more rarely be caused by the sudden or gradual laceration of peri-ovarian or peri-uterine adhesions, or by the rupture of a hæmatosalpinx. In exceptional cases the effused blood may be encapsuled by an organized membrane, and in the omentum more often than not will be found to form part of the sac. More commonly a false capsule is formed by condensation of the outer fibrinous layer of the extravasation. In a few cases remains of the walls of the tube may still define the capsule (Roncagila). The treatment should be expectant unless (1) the tumor, instead of diminishing, undergoes sudden enlargements; (2) or is complicated by continued hemorrhage; (3) or when feverish attacks threaten an alteration in the extravasated blood; (4) or when from loss of health, social condition, or other cause, the patient cannot afford the necessarily protracted rest in bed. If operative the treatment should be laparotomy, or, in case of suppuration, incision of the sac from the vagina; and perhaps occasionally, in case of a very small tumor, vaginal cœliotomy, never hysterectomy (Jacobs). Pestalozza gives 30 cases of his own; 14 healed spontaneously; 16 operations. One case ended fatally from suppuration of the sac perforating the anterior wall of the rectum.

***The Placenta in Ectopic Gestation.***—Dr. Vignard (Sem. Méd.), in two cases where a dead fetus was extracted, fixed the sac to the lower end of the wound, leaving the placenta. A few strands of gauze were loosely packed in the sac and withdrawn at the end of the third or fourth day. Afterward the cavity of the sac was left quite untouched, and the orifice simply dressed with the rest of the abdominal wound. No evil results ensued, and the placenta in each case was slowly absorbed.

***Common Abortion and Tubal Pregnancy.***—Dr. Skutsch (Centralbl. f. Gynäk.) lends his authority to support, by a case under his own observation, the theory that in tubal abortion the ovum is not invariably expelled from the ostium of the tube, but may be discharged into the uterus. In his case a complete decidua was discharged; its walls measured four millimeters in thickness. Afterward the ovum was expelled; it bore a minute aperture at its lower pole. Skutsch insists that there had been tubo-uterine or interstitial pregnancy, and that the ovum had been delivered into the uterus. This diagnosis was supported by the detection of a thickening of the right cornu. Tubal gestation is undoubtedly very common, and Skutsch goes so far as to say that though tubo-abdominal abortion is the more frequent complication, next to rupture, tubo-uterine abortion is not rare.

***Differentiation of Hysterical and Epileptic Attacks.***—Dr. Bonjour.—Rivista Clinica e Therapeutica.—The differential diagnosis of these two states is at times difficult, and therefore their characteristic features are presented. The Prodromal Stage.—The aura is rarely lacking in epilepsy; the hallucinations may make the epileptic an assassin or an incendiary. In hysteria the aura is of longer duration and lighter. The "initial cry" in both states is always loud; in the epileptic it is horrible and penetrating. Then the epileptic becomes unconscious and falls, often injuring herself; the hysteric falls without wholly losing consciousness, and never hurts herself. At the beginning of the epileptic attack the pupil dilates, and does not become modified under the influence of light; the face subsequently becomes terribly congested, and much saliva flows from the mouth. Hysterics only present swelling of the face and occasionally salivation. The epileptic turns the eyes upward, and they move

rapidly in their orbits, while the whole body is shaken by tonic convulsions, the skin turns cyanotic, and symptoms of asphyxia set in ; the hysteric only has tonic convulsions, and the thumb is never flexed under the index finger. Clonic convulsions follow the epileptic seizure, and are violent, the patient turning, rising and falling on the bed, and falls if not held. The hysteric generally limits herself to opisthotonos, with the arms flexed and the legs extended. Incontinence of urine and fæces, frequent in epileptics, is absent in hysterics. In epilepsy the pulse is small, filiform, so that sometimes it cannot be counted. In hysterics it changes from one to the other, and is different on each side. The epileptic attack terminates nearly always slowly, rarely suddenly. The patient may resume occupation, sleep, or have slight delirium. The hysteric attack usually ends brusquely ; sometimes the patient is seized with a deep sleep, but suffers from hallucinations, yet never from mental alienation. The absence of the pupillary reflex is an exclusive characteristic of epilepsy. Hypnotism has a striking influence in hysteria, for with a few sittings one may cause the attacks wholly to vanish.

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## Obstetrics.

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***Controlling Hemorrhage after Labor.***—Dr. H. Crutcher.—Briefly, a vigorous irritation of the cervical endometrium will cause substantial uterine contraction. This remedy can be applied without delay, and does not prohibit the employment of other expedients should they be deemed necessary ; a clean forefinger being the only instrument needed. It is, however, in my experience sufficient, and its value has been amply demonstrated where other recognized methods have failed. Certainly the one vital point is the prompt production of uterine contraction, and this being gained, nothing more is to be desired. My usual procedure in any case of labor is to watch carefully the pulse after the delivery of the placenta, and if the rate is well below a hundred I do not anticipate bleeding. A sudden rise of

the pulse demands instant attention. If bleeding be present, the index finger is rapidly inserted into the cervix and the endometrium gently curetted with the finger-nail. The left hand may be used to apply pressure over the fundus. It is very gratifying to note the response to this action. It is unnecessary in any case to inflict damage upon the membrane by hasty and ill-considered movements. In no case has it been necessary to prolong the treatment to secure a response. It is important to confine the irritation to the cervical segment. Irritation applied to the corporeal endometrium possesses a certain value, but the area near the cervix yields incomparably better results. Generally the treatment is begun by clearing the débris from the uterus; using at first two or more fingers for purposes of irritation, withdrawing a finger as it is impinged by the contracting organ until only the index finger remains. With the remaining finger I continue a degree of irritation until all danger is past.

***Dangers of Membranous Insertion of Cord.***—Dr. Lefèvre.—Thèse de Paris.—This condition is most frequent in twin pregnancy. Undoubtedly it exposes the fetus to dangers during pregnancy as well as in labor. During gestation it may involve premature rupture of the membranes; in six cases at least no other reason could be found. Premature labor may be caused by membranous insertion of the cord, and this anomaly of the funis may explain certain cases of hydramnion and fetal dropsy. In labor some cases of premature rupture of the membranes is due to membranous insertion, but it appears to be not so frequent a cause of that accident in labor as in pregnancy. Membranous insertion is a predisposing cause of prolapse of the funis. In 2 of 151 cases the fetus was killed during labor through the anomaly in question, but it is important to remember that in both the death was due to pressure on the membranous insertion, and in no instance to tearing off the cord; in fact, it would seem that a labor pain would not cause the fetus to tear off a cord of this kind, though it is easy to understand how it may cause great danger from pressure.

***The Causation and Treatment of Secondary Puerperal Hemorrhage.***—Dr. Amand Routh.—Brit. Med. Jour.—Secondary post-partum hemorrhage might be defined as that which occurred

from the time the accoucheur had left the case, and considered the patient to be in a normal state, to the end of the puerperium. There are two main varieties, that of concealed, and that of external hemorrhage. The causes of secondary post-partum hemorrhage were numerous ; uterine inertia suddenly induced by emotion or fright ; partial detachment of a piece of retained placenta, the adherent portion of the placenta preventing uterine retraction ; detachment of thrombi by exertion, or sudden exhibition of ergot detaching a retained piece of placenta. Ergot, given before the birth of the child, if the uterus were in a state of exhaustion, led to irregular uterine contraction, and might be one of the causes of concealed post-partum hemorrhage, inducing reversal of uterine polarity, when, after the birth of the child and placenta, spasm of the fibers at Bandl's ring occurred, clots could not be expelled, and the uterine body, already in a state of inhibition, passively distended so that it might become as large as a full-term uterus, and the patient die from hemorrhage into the cavity of the organ, with no external evidence of bleeding whatever. In the concealed variety the uterus was found greatly distended and somewhat flaccid, and the patient evidently suffering from internal hemorrhage. In such a case examination per vaginam would reveal a closed or blocked internal os, or rather contraction at a point above that level. The method of treatment was to insinuate the hand at once past the point of constriction, and with the help of the outside hand empty the uterus, mold it to induce contraction and retraction with the inside fist against the placental site, and at the same time press the uterus with its contained hand against the abdominal aorta. Help might be also afforded, while the hand was in utero, by hot water at a temperature of 118° F. being allowed to irrigate the uterus ; this produced thrombosis as well as uterine contraction. If external severe hemorrhage occurred before the third day, one or two fingers should at once be passed into the uterus, and its surface carefully explored for pieces of placenta ; they should be detached by the finger, and the operator should be prepared to plug the uterus at once with antiseptic gauze, which would almost surely stop the hemorrhage, which might become very alarming. After the third day, if necessary, the cervix should be



dilated with bougies, for it was essential to explore the cavity, and not trust to a hope that nothing was left behind. In a word, the uterus should be emptied and uterine retraction induced.

***Influence of Lead-Poisoning on the Course of Pregnancy.***

—Dr. J. Ballaud, Paris.—In the statistics of Baudelocque's clinic in Paris there were thirty pregnant women in the last six years who showed symptoms of lead-poisoning. They had altogether eighty-two pregnancies with only twenty-four labors at the normal term of pregnancy; the remainder ended in premature labor or abortion. These women were employed as compositors, with painters, in a jewelry factory, or in the manufacture of artificial flowers. Further inquiry showed that pregnant women employed in these occupations either aborted or gave birth prematurely to a sick child. A nursing dog fed with lead had the pups affected and become emaciated. Lead-poisoning is, therefore, a contra-indication to nursing.

***Pregnancy Lasting Eleven Months.***—Wigodsky (Medicinsk. Obosrenie) observed protracted gestation in a III-para, aged twenty-eight. The last period was on September 7, the fetal movements were first felt at the end of January, and labor occurred on August 13. Pregnancy otherwise ran a natural course. Delivery was delayed by the great breadth of the shoulders, and the forceps was applied. The fetus was a living anencephalus.

***Rupture of Recto-Vaginal Septum in Labor.***—Drs. Doléris and Lenoble (Bull. et Mém. de la Soc. Obstét. et Gynéc. de Paris) report the delivery at term of a very anæmic, nervous, and tuberculous young woman. During pregnancy she had mumps and severe neuralgic attacks periodically, replacing the absent menstrual flow. Mentally she was very timid, and not only had she suffered from dyspareunia due to vaginismus, but vaginal exploration before and during labor was always attended with severe muscular spasm. The presentation was first position vertex; as there was delay in the second stage the forceps was applied under chloroform. The child was delivered, and a superficial laceration of the perineum sewed up at once with catgut. On the second day flatus, and on the eighteenth fæces, passed out of the vagina. Then the wound in the perineum had given way. The

sphincter ani was uninjured, half an inch above it, and a little to the left of the middle line, was a distinct fistulous orifice filled with everted rectal mucous membrane. It was successfully repaired. Doléris and Lenoble found that the rupture occurred in the retroperitoneal sinus, a gap between the perineal muscles and the levator ani. The spasm of the muscles drove the fetal head against this space, where there is no muscular support, and the septum yielded. They quoted evidence in support of the theory of spontaneous rupture of the septum due to vaginismus, and declared that the injury, in their case, could not have been caused by the forceps.

**The Treatment of Face Presentation.**—Dr. Knoor, Berlin (Centralblatt für Gynäkologie), recommends Thorn's method as the best, by manual reposition into occipital position, as it does not require assistance. The operator accomplishes by it the best of Baudelocque's and Schatz's methods (drawing down the occiput or pressing up the face with external pressure on the breast). He considers drawing up the occiput with the internal hand more certain than pressing up the face. The operation should be performed under ether. The prophylactic treatment of all face positions in this manner is to be condemned, as the operation is only indicated when difficulties arise in the course of labor. It is also contra-indicated in the higher degrees of pelvic contraction.

**Dysmenorrhea.**—Brit. Med. Jour.—Dr. J. D. Williams wished to call attention to one aspect only of the subject—namely, that presented by the coexistence of painful menstruation and acute ante flexion of the uterus. The class of patients who suffered from this type of disease were usually, if married, sterile, and the supervention of pregnancy often effected a cure; the pain which they suffered was colicky in nature, was felt in the hypogastric region, and dated from puberty. Pelvic examination revealed the absence of any inflammatory lesion, the uterus bobbed up and down on the examining finger with great mobility, and was sometimes displaced backward, sometimes to one side. The passage of the sound was, in some cases, a painful process. The degree of ante flexion might be in excess of the normal, but still not be pathological, for according to Shultze, who first

described the condition, there was in that lesion an inflammatory shortening of the utero-sacral ligaments. The pain of dysmenorrhea was probably due to irregular abnormal contractions, set up by a diseased condition of the mucous membrane at the seat of flexure. Since the researches of Vedeler and Herman it was no longer fashionable—and rightly so in the speaker's opinion—to speak of obstructive or mechanical dysmenorrhea, and one must search for some cause other than the angulation-blockage at the seat of flexion, operating either alone or in conjunction with the flexion, to account for the painfulness of the menstruation. Dilatation was successful to some measure—that is to say, the pain was kept away from three to six months, but returned later. Dilatation, performed a second and third time, yielded slightly better results, but never a complete cure. Very good results followed the performance of Dudley's operation, which consisted in incising and removing a wedge-shaped portion from the posterior lip in this type of cases.

***On Perforation of the After-coming Head.***—Dr. C. E. Purslow.—Brit. Med. Jour.—I have been called upon to perforate the after-coming head on three recent occasions. On the first I perforated in the situation usually advised; namely, behind the ear; in the other two I perforated through the roof of the mouth, and I desire to call attention to the advantages possessed by the latter site:

In all these cases pulsation in the cord had ceased for some time before perforation was performed, so that the painful experience of destroying a living child was spared. All three cases made an uneventful recovery. The following, in my opinion, are the advantages possessed by perforation through the roof of the mouth as compared with that operation behind the ear. The operation is easier and safer because the perforator is not by any means so likely to slip, as it impinges practically at right angles on the bone to be gone through, and is protected by the alveolar ridges, whereas behind the ear it must impinge at an acute angle and it is very difficult to keep it from slipping, especially when much force has to be applied. Not so much force is required, the bone in the mastoid region is very thick, and in addition, at the usual site of perforation, is covered by the attachment of

muscles. Another important point is that by this method the attachment of the head to the body is not weakened, as it is by many of the other methods proposed. This is a serious consideration, for the amount of tractile force that has to be applied is sometimes considerable, and if the neck has been weakened it may give way and the head be left behind in the uterus, and its subsequent extraction is then a matter of great difficulty. Perforation through the roof of the mouth has a further advantage, in that it breaks up the base of the skull, and so allows it to pass through a smaller diameter than would otherwise be possible.

The disadvantages of this method are two : The first is that the brain matter will not flow so readily through the opening, but this can be easily overcome by passing the tube of a Higginson's syringe through the hole, and washing out the brain.

The second disadvantage is one which I have not seen mentioned in any of the books I have referred to, and this is that the pressure of the perforator on the roof of the mouth tends to cause extension of the head. This may operate injuriously in two ways : first, by causing greater difficulty in the mechanism of the passage of the head through the pelvis ; and, secondly, in the extended position of the head, it is possible to pass the perforator through the maxilla and into the orbit, not entering the cranial cavity at all, and if passed too far in this direction the point may emerge and injure the uterine wall. In the last of the cases recorded above, I found that, after passing the perforator the usual distance, no brain matter escaped. I then reintroduced it in a more backward direction, and tapped the cranial cavity. On examining the head afterward I found that, on its first introduction, the point of the perforator had entered the orbit. If the possibility of this accident is borne in mind, it can easily be guarded against by passing the blades in a sufficiently backward (with reference to the head) direction. I may say that I always use Oldham's perforator, and consider it a vastly superior instrument to Simpson's.

## Pediatrics.

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**Infantile Cause of Epilepsy.**—Archives of Pediatrics.—The most frequent cause of infantile epilepsy is rachitis. Clouston has also emphasized its influence in the production of other nervous diseases. It was Sir William Jenner who demonstrated that the condition of rickets is a general retardation of development, with various secondary necessary results, and of the association of convulsions with this general state. Backward teething is also a manifestation, but is now fully understood not to be a cause in itself of the convulsions of infancy. These are a consequence of the retarded development which occurs so often toward the end of the first year. It is the epoch at which the character of the food supply undergoes change, or does not undergo the change that is natural. It is also a period when much functional capacity passes into functional use. The influence of rickets in causing the convulsions of infancy is of great importance in connection with epilepsy. They leave behind a residual disposition to a like morbid action, which may be continuous in its results, or may become active at a later period in life. Every variation of interval is met with. It is impossible to doubt that the convulsions of dentition are a definite element in the causation of epilepsy. And it is also impossible to doubt that the prevention of rickets would have a considerable influence on the prevention of epilepsy.

**An Epidemic of Juvenile Paralysis.**—A number of cases of paralysis of the throat have occurred in Hackensack, N. J., during the summer and fall, which have been very puzzling to the physicians. Some cases have been ascribed to malaria, but in one case which resulted fatally—the eight-year-old son of Dr. C. F. Adams—there were no evidences of it. Only one theory has been advanced, and that by the father. About a month ago the son had some symptoms which might have been the premonition of an attack of scarlet fever, which often involves the throat. These passed away, however, without developing, and the child was well until this fatal attack. In the other cases the paralysis

followed upon malarial diseases. The only writer who refers to an epidemic of juvenile paralysis is Professor Orser of Johns Hopkins University.

**Not** the least of the merit of Antikamnia consists in its rapid effect in alleviating the suffering of the patient while the indicated treatment is working a cure. While treating a patient for after-pains, mastitis, etc., this remedy secures relief from pain. In short, while not a remedy for any disease, it is a most useful adjuvant in relieving the great symptom—pain.

**Symptomatology of Pseudo-Rheumatism.**—Dr. Martin Deschere.—In speaking of the symptomatology of rheumatism, I was thinking that it might not be out of place to speak of the similarity of some of the common diseases. We find swelling, and the parts become thick and large; there is fever and partial paralysis in some of the extremities. Many of these cases have been considered rheumatism, and have been treated as such, and the child has been suffering intense pain and agony all the time, the treatment not having had any effect on the disease. These conditions should be treated by diet only. On close examination we find the swellings in the long bones of the extremities of the patient hard, smooth, and painful, as I have said. This is so aggravating and painful that the child experiences pain even when undressing; the fever is there, varying with morning and evening exacerbations between  $99\frac{1}{2}^{\circ}$  and  $101\frac{1}{2}^{\circ}$ , probably; the gums have the symptoms of general inflammation; they are very tender, and blood will be drawn on touch; again, you will find that the child has had some kind of a hemorrhage, either of the nose or mouth.

**Rheumatism after Scarletina.**—Dr. J. L. Hanchett.—A child, six years of age, had scarlatina at the time I saw her in Washington, D. C. The mother of the child thought that the child was not having the proper care by the attending physician when I was called. The other members of the family were so fearful lest this condition should spread that the child was exposed, and thus allowed to become rheumatic. On examination of the heart I found that there was a pronounced enlargement of the heart, with strong rheumatic symptoms, and nearly the whole of one side paralyzed. In this case we had a child suffering, no doubt,

with rheumatism, with enlargement of the heart, and with a great deal of the nervousness of a choreic condition. Every physician should especially guard against any eruptive diseases, either before or after rheumatic troubles. The rheumatic diathesis may be inherited, I am convinced. Scarlatina may be a single prodromal to rheumatism, and when once this has been established it is a difficult thing to cure, as these conditions are next to incurable; they will follow these patients nearly all through their lives.

**Nutrition in Rheumatism.**—Dr. E. S. Bailey.—I think it would be a difficult matter to present a résumé of the treatment, and demonstrate all the treatments which will give results. Now, I wish to refer to the primary conditions of nutrition. Two considerations present themselves in the matter of nutrition; one is the ingestion of foods, and the other of the elimination of the waste matters of the system. I have found that it is not so hard to eliminate as it is to secure the proper taking of the foods by the patient. We should see to it that we get proper elimination of the waste matters, then. Hence, in every case of rheumatism we should see to it that these conditions are in proper working order, continually, throughout the course of the disease. I have nothing to say with reference to the general form of treatment; it meets my approval. When we come to the matter of the secretions and the retention of the solids of the different waste matters and products, we have only to use our common sense in order to be able to see to what we should pay our attention. With reference to the symptoms which present themselves to us, and the condition of the patient in general, I think we can usually cure with rational methods and a carefully selected homeopathic remedy. I have not much faith in the salicin and other similar compounds of this class. Bryonia has been a most excellent remedy in my hands. I also place very early in the list of my remedies, in rheumatism and all rheumatic affections, aconite. I place this early, I say. I have learned to rely on the frequent administration of aconite. Anything that will unlock the vasomotor system as aconite will, assists in the progressive elimination of the waste matters and will help in the cure of the rheumatic affection. Gelsemium is also a good remedy. It is hard to select between gelsemium and bryonia, many times. My list is not all complete if I don't mention gelsemium and bryonia, which two remedies will do such excellent work. To my mind, I could not treat these cases well if I could not have these remedies.

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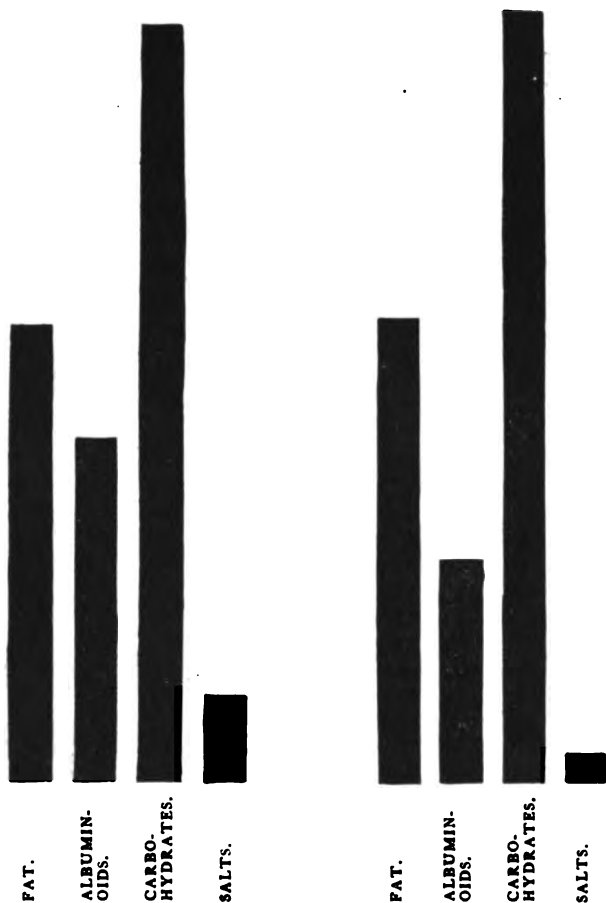
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### Pneumonia Following La Grippe.

BY M. E. CHARTIER,

Docteur en Médecine de la Faculté de Médecine  
de Paris, Membre Correspondant étranger  
de la Grande Encyclopédie, Section  
de Philologie.

As a rule certain diseases prove more fatal, not only in given districts, but during certain periods of time, along particular areas of territory. We have La Grippe, decreasing in intensity for the present; it has been replaced by pneumonia, which is not only raging in the United States, but in European countries. The bacteriologists will have to explain this fact; the truth remains however, that the mortality from pneumonia in its various forms is now far in excess of any previous record.

Twenty years ago, and preceding the re-appearance of La Grippe in its epidemic form, pneumonia proved as dangerous as it does at the present time. Many cases fell under my personal observation, and I must admit that my Parisian confreres were at a loss, not for a remedy for the disease alone, but even for a logical line of treatment. Dujardin-Beaumets became so skeptical that he prescribed stimulants, regardless of therapeutical conditions. The mortality in his ward at the Hotel Dieu proved that his patients fared no worse than the others submitted to the antiphlogistic remedies then en vogue.

At that time, I advocated in my treatise on therapy, the administration of sulphate of codeine in two to five centigrammes doses—one-

fourth to one-half grain. Codeine is the only remedy known to me possessing a marked and distinct effect upon the hypersecretions of the bronchial mucous membrane. What I then wished was an analgesic possessing antipyretic properties, which I could safely use. This I have since found in antikamnia and I believe it can be exhibited safely, especially on account of its not having a depressing effect on the cardiac system.

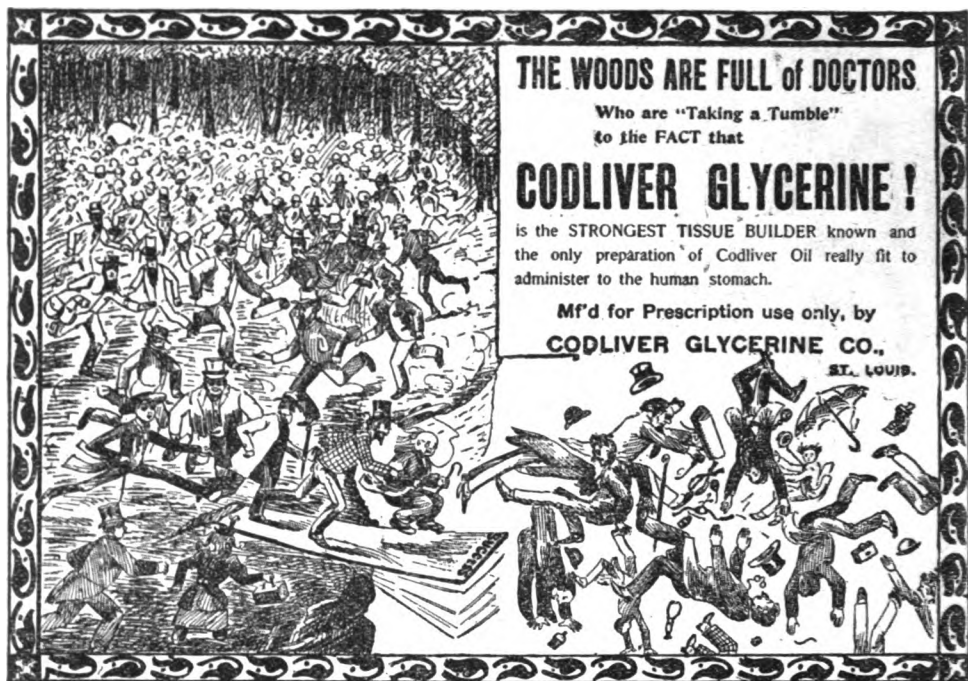
Experimental doses of from one-half to one gramme—seven to fifteen grains—of antikamnia administered under ordinary conditions did not develop any untoward after-effect. In the following trace, taken with the sphygmograph was made ten minutes after the administration of one gramme—fifteen grains—of antikamnia.



Pulse, 112. Temp., 101.5 Fahr.

The above trace shows plainly that unlike other coal-tar products, antikamnia has a stimulating effect upon the circulation. In this particular case the temperature was sensibly reduced—102° to 101.5°. The analgesic effect of the drug was satisfactory.

My conclusion is that in the treatment of pneumonia, antikamnia is indicated as a necessary adjunct to codeine, on account of its analgesic and antipyretic properties and particularly because it acts as a tonic upon the nerve centres. The tablets of antikamnia and codeine containing four and three-quarter grains antikamnia and one-fourth grain sulphate of codeine, to my mind, present these two remedies in the most desirable form. I also find one tablet every hour, allowed to dissolve slowly in the mouth, almost a specific for the irritating cough so often met with in these complications. For general internal medication, it is always best to crush the tablets before administration.



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Please order one (1) doz. bottles of Codliver Glycerine from your wholesale druggist. This card sent with the order secures a discount from the bill, of the price of one bottle. That bottle will be sent you free for me. The price is \$8.00 per doz. (less discount for this one bottle). I agree to prescribe at least the amount of this order.	
M. D. ....	
.....Wholesale Druggist.	
Send me one doz. Codliver Glycerine and hold this card against Codliver Glycerine Co. of St. Louis, for payment of one bottle of same.	
.....Druggist.	
Received by.....	.....189
.....Wholesale Druggist.	
To the Jobbers:—This card returned to us bearing your official stamp, credits you with one bottle Codliver Glycerine, (66 ⅔ cents.) at rates to retailers.	
Codliver Glycerine Co.	St. Louis, Mo.

THE HOMEOPATHIC JOURNAL OF OBSTETRICS.

"WELL PREPARED!! NUTRITIOUS!! EASILY DIGESTED!!"  
 HIGHEST AWARDS WHEREVER EXHIBITED THE WORLD'S COLUMBIAN COMMISSION.

# IMPERIAL GRANUM

THIS STANDARD PREPARED

# FOOD

**IS** EARNESTLY RECOMMENDED as a most reliable FOOD for INFANTS, CHILDREN and Nursing-Mothers;—for INVALIDS and Convalescents;—for Delicate and Aged persons. It is not a stimulant nor a chemical preparation; but a PURE, unsweetened FOOD carefully prepared from the finest growths of wheat, ON WHICH PHYSICIANS CAN DEPEND in FEVERS and in all gastric and enteric diseases. It is easily digested, nourishing and strengthening, assists nature, never interferes with the action of the medicines prescribed, and IS OFTEN THE ONLY FOOD THE STOMACH CAN RETAIN.

SEEMS TO HOLD FIRST PLACE IN THE ESTIMATION OF MEDICAL OBSERVERS.—*"The Feeding of Infants," in the New York Medical Record.*

A good and well made powder of pleasant flavour. CONTAINS NO TRACE OF ANY IMPURITY.—*The Lancet, London, Eng.*

A valuable aid to the physician in the treatment of all the graver forms of gastric and enteric diseases.—*The Prescription.*

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The results attending its use have been very satisfactory.— \* \* \* M.D., in *New York State Medical Reporter.*

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JOHN CARLE & SONS, Wholesale Druggists, 153 Water Street, NEW YORK CITY.





## Sick-rooms in winter

require disinfecting and deodorizing more than at any other season.

Tightly closed doors and windows render thorough ventilation impossible.

To prevent mal-odors and destroy disease germs, keep Platt's Chlorides in the vessels receiving the discharges.

To purify the air, a towel or cloth moistened with Platt's Chlorides should be frequently wafted about and then hung up in the room.

# **Platt's Chlorides,** **The True Disinfectant.**

An odorless, colorless liquid ; powerful, safe, and economical; sold in quart bottles only, by druggists everywhere. Prepared only by HENRY B. PLATT, Platt Street, New York.

## THE NEW CHAMPAGNE VINTAGE

The new vintage of G. H. MUMM & CO.'S EXTRA DRY now coming to this market is eliciting universal admiration on account of its very superior quality and dryness, without being heavy, making it a perfect wine in the true sense of the word.

## IMPORTS OF CHAMPAGNE INTO THE U. S.

For the Year 1896.

	CASES.
G. H. MUMM & CO.'S EXTRA DRY, .	70,548
POMMERY & GRENÔ, . . . . .	33,598
MOËT & CHANDON, . . . . .	28,069
HEIDSIECK & Co., . . . . .	17,344
VVE. CLICQUOT PONSARDIN, . . . . .	11,661
PIPER HEIDSIECK, . . . . .	9,410
RUINART, PÈRE & FILS, . . . . .	9,157
LOUIS RÖDERER, . . . . .	8,461
PERRIER-JOUËT & Co., . . . . .	8,403
GEO. GOULET, . . . . .	4,985
ERNEST IRROY & Co., . . . . .	3,257
VARIOUS BRANDS (20 or more), . . . . .	18,396
TOTAL, . . . . .	223,289

It is a noted fact that G. H. MUMM & CO. use only the finest wines in the composition of their cuvées, hence the unsurpassed quality, purity, and natural dryness of their EXTRA DRY.

By chemical analysis of Prof. R. Ogden Doremus it contains the least amount of alcohol, therefore the purest and most wholesome Champagne.

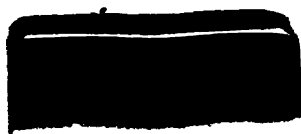
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